1827 Powers Ferry Road SE, Bldg. 14, Suite 250, Atlanta, GA 30339
www.HealingCenter4Change.org
(678) 800-1329

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

The Healing Center for Change is extremely grateful and honored that you have selected our program to provide services to you and/or your family. We truly sincerely look forward to assisting you. This document is designed to inform you about what you can expect from our organization regarding confidentiality, emergencies, and several other important details regarding your treatment.

Although providing this document is part of an ethical obligation to our counseling profession, more importantly, it is part of our commitment to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with our organization is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to 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 effective to reach your desired goals and objectives.

Confidentiality & Records

Your communications with me will become part of a clinical record of treatment, which is referred to as your Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our office. **Additionally, we will always keep everything you say completely confidential, with the following exceptions:** **(1)** you direct us to tell someone else and you sign a "Release of Information" form; **(2)** we determine 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)** we are ordered by a judge to disclose information. In the latter case, our professional license does provide us 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 therapist. The state of Georgia has a very good track record in respecting this legal right. If for some 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. Please note that in couple's counseling, we do not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Structure and Cost of Sessions

We agree to provide counseling and psychotherapy services for the fee of $100 to $130 per 50 minute session, $150 per 75 minute session, unless otherwise negotiated by you or your insurance carrier. Doing psychotherapy by telephone is not ideal, and needing to talk to me between sessions may indicate that you need extra support. If this is the case, we will need to explore adding sessions or developing other resources potentially available to help you. Telephone calls that exceed 10 minutes in duration will be billed at $10 per minute. The fee for each session will be due at the conclusion of the session. Cash or debit/credit cards are acceptable for payment, and we will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable.

Insurance companies have many rules and requirements specific to certain plans so it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. I 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.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for paying a cancellation/reschedule fee of $75.00, this fee also applies to all appointments that are canceled on the same-day of your appointment. All unpaid fees will be submitted to a collection agency if unpaid after 45 days of the original appointment date.

In Case of an Emergency

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 a beeper nor are we available at all times. If at any time this does not feel like sufficient support, please inform us, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, we will return phone calls within 48 hours. 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 by contacting any of the following:

- Ridgeview Institute at (770) 434-4567
- Peachford Hospital at (770) 454-5589
- Georgia Crisis & Access Line at (800) 715-4225
- Call 911 or go to your nearest emergency room

Professional Relationship

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, your relationship with the Healing Center for Change and its employees 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/or any employee from our organization were to interact in any other way (e.g., social, business, etc.), we would then have a "dual relationship." Dual relationships may compromise our treatment and are discouraged in the mental health profession. In order to offer all of our clients the best care, our judgment needs to be unselfish and purely focused on your needs. This is why your relationship with our organization must remain professional in nature.

Additionally, you should also know that therapists are required to keep the identity of their client's secret. In this case, we would like to strive to remain confidentiality by not addressing you in public unless you speak to us first. We also are required to decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, we will not be able to be a friend to you like your other friends. Please note that these guidelines are not meant to be discourteous in any way; they are strictly for your long-term protection.

Technology 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 that we maintain your confidentiality, respect your boundaries, and ascertain that our relationship remains therapeutic and professional. **Therefore, we have developed the following policies**:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. If you would like for us not to use a cell phone when contacting you, please let me know.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text and/or email because it is a quick way to convey information, but will only be used to confirm appointments. Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. You also need to know that we are required to keep a copy of all emails and texts as part of your clinical record.

Facebook, LinkedIn, Etc: It is our policy not to accept requests from any current or former client on social networking sites such as Facebook or LinkedIn because it may compromise your confidentiality. Additionally, our ethics code prevents us from soliciting endorsements from clients.

Please initial that you have read this page __________

Google: We do not search for clients on Google. We respect your privacy and make it a policy to allow you to share information about yourself to me as you feel appropriate.

Twitter & Blogs: We post psychology news on Twitter, and we write a blog on our website. If you have an interest in following either of these, please let me know so that we may discuss any potential implications to our therapeutic relationship. Once again, maintaining your confidentiality is a priority. We would recommend using an RSS feed or locked Twitter list, which would eliminate you having a public link to our content.

Statement Regarding Ethics, Client Welfare & Safety

We assure you that our services will be rendered in a professional manner consistent with the ethical standards of the American Counseling Association (ACA). If at any time you feel that we are not performing in an ethical or professional manner, we ask that you please let me know immediately. If we are unable to resolve your concern, we will provide you with information to contact the Georgia professional licensing board that governs our profession.

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, with your participation, we 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 the 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.

****

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 ask!!!!!

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 me as your therapist, and you are authorizing me to begin treatment with you.

______________________________ ______________

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

Signature below indicates that we have discussed this form and answered any questions you had during intake.

______________________________ ______________

Therapist's Signature **Date**

Please initial that you have read this page __________

ADDENDUM: COUNSELING SERVICES PROVIDED TO A MINOR

Privacy practices are modified when the targeted client is a minor. This addendum is an extension of the information, authorization, and consent to treatment form listed above on previous pages. The information provided is also applied for all counseling relationships with the Healing Center for Change and its employees.

Your Health Information Rights

Although your health record is the physical property of the practice and the clinician that has completed it, you have the right to:

- **Right to clinical records:** Parents/guardians of a minor are privileged to view the clinical record of that minor client.
- **Release of Information:** Any requests for release of information are to be signed by the parent/guardian of the minor client.
- **Release of information without consent from parent/guardian:** Just as with adult clients, there are exceptions specific circumstances in which release is not required to share information. These circumstances involve current or risk of harm to self or others.
- **Legal use of clinical records:** Participation in therapeutic services with the Healing Center for Change does not automatically serve as sustenance for custody and/or divorce mediation. Should this matter arise, it must be discussed with the therapist prior to releasing the information to related third parties. This helps to ensure the appropriateness and allow for proper referral to providers that specialize in such matters if such referral is needed.
- **School records:** should school records be deemed relevant and helpful to the therapeutic process, permission must be first obtained from the parent/guardian of the minor client. This also applies to situations in which collaboration with school staff are deemed appropriate and necessary.
- **School input:** Your child's therapist may give you questionnaires/checklist/inventories and request school staff to complete and return them. The parent/guardian has the right to refuse.

Right to Privacy: In order to better support the child, individual counseling with a minor client can often involve family sessions as a compliment to the individual sessions. During times when parents/guardians are present for therapy sessions with the minor child, it is expected that all parties reserve the child's privacy and refrain from discussing the sessions outside of the present parties unless previously discussed.

Please initial that you have read this page __________

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Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES

Effective 2/01/2015

I. COMMITMENT TO YOUR PRIVACY: The Healing Center for Change 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. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that The Healing Center for Change 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, the Healing Center for Change is required to ensure that your PHI is kept private. This Notice explains when, why, and how the Healing Center for Change would use and/or disclose your PHI. Use of PHI means when the Healing Center for Change shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when the Healing Center for Change releases, transfers, gives, or otherwise reveals it to a third party outside of the Institute. With some exceptions, the Healing Center for Change 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, the Healing Center for Change 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 the Healing Center for Change. Please note that the Healing Center for Change 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 the Healing Center for Change has created or maintained in the past and for any of your records that the Healing Center for Change may create or maintain in the future. The Healing Center for Change 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 the Healing Center for Change Notice of Privacy Practices.

IV. HOW YOUR NAME MAY USE AND DISCLOSE YOUR PHI: The Healing Center for Change 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:
The Healing Center for Change 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, the Healing Center for Change may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, the Healing Center for Change will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations:
The Healing Center for Change may disclose your PHI to facilitate the efficient and correct operation of its practice. Example: Quality control – The Healing Center for Change may provide your PHI to its office personnel, accountants, practice consultants, attorneys and others to make sure that the Healing Center for Change is in compliance with applicable practices and laws. It is the Healing Center for Change practice to conceal all client names in such an event and maintain confidentiality. However, there is still a possibility that your PHI may audited for such purposes.

3. To Obtain Payment for Treatment:
The Healing Center for Change may use and disclose your PHI to bill and collect payment for the treatment and services provided to you.

Example: The Healing Center for Change 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. The Healing Center for Change could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for our office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, the Healing Center for Change 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 the Healing Center for Change 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, the Healing Center for Change 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 the Healing Center for Change.

Note: Georgia 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 the Healing Center for Change may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – YOUR NAME

may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, the Healing Center for Change may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: The Healing Center for Change may make a disclosure to the appropriate officials when a law requires the Healing Center for Change to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** The Healing Center for Change may disclose information about you to respond to a court or administrative order or a search warrant. The Healing Center for Change 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. The Healing Center for Change 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.
3. **Public Health Risks:** The Healing Center for Change 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):** The Healing Center for Change 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:** The Healing Center for Change 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 the Healing Center for Change determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, the Healing Center for Change 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), the Healing Center for Change may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** The Healing Center for Change may disclose PHI if

mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If the Healing Center for Change has a reasonable suspicion of child abuse or neglect, the Healing Center for Change will report this to the Georgia Department of Child and Family Services.

8. **Coroners, Medical Examiners, and Funeral Directors:** The Healing Center for Change 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. The Healing Center for Change may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** The Healing Center for Change 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, The Healing Center for Change 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, the Healing Center for Change may release PHI about you as required by military command authorities. The Healing Center for Change may also release PHI about foreign military personnel to the appropriate military authority.
11. . **National Security, Protective Services for the President, and Intelligence Activities:** The Healing Center for Change 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, the Healing Center for Change 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, the Healing Center for Change 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:** The Healing Center for Change may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. . **Appointment Reminders:** The Healing Center for Change 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:** The Healing Center for Change 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 the Healing Center for Change compliance with HIPAA regulations.
17. . **If Disclosure is Otherwise Specifically Required by Law.**

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, the Healing Center for Change will ask for your written authorization before using or disclosing medical information about information. If you chose to

authorize use or disclosure, you can later revoke that authorization by notifying the Healing Center for Change in writing of your decision. You understand that the Healing Center for Change is unable to take back any disclosures it has already made with your permission, the Healing Center for Change will continue to comply with laws that require certain disclosures, and the Healing Center for Change is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. . The Right to See and Get Copies of Your PHI: In general, you have the right to see your PHI that is in the Healing Center for Change possession, or to get copies of it; however, you must request it in writing. If the Healing Center for Change does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from the Healing Center for Change within 30 days of receiving your written request. Under certain circumstances, the Healing Center for Change may feel it must deny your request, but if it does, the Healing Center for Change will give you, in writing, the reasons for the denial. The Healing Center for Change will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged not more than $.25 per page and the fees associated with supplies and postage. The Healing Center for Change 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 the Healing Center for Change limit how it uses and discloses your PHI. While the Healing Center for Change will consider your request, it is not legally bound to agree. If the Healing Center for Change does agree to your request, it will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that the Healing Center for Change is legally required or permitted to make.

3. The Right to Choose How YOUR NAME 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). The Healing Center for Change 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 the Healing Center for Change 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 May 11, 2014.

The Healing Center for Change 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. The Healing Center for Change 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 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 the Healing Center for Change 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 the Healing Center for Change receipt of your request. The Healing Center for Change 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 the Healing Center for Change 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 the Healing Center for Change denial will be attached to any future disclosures of your PHI. If the Healing Center for Change approves your request, it will make

the change(s) to your PHI. Additionally, the Healing Center for Change 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 the Healing Center for Change and Dr. Ryan T. Day, 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 the Healing Center for Change 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. The Healing Center for Change 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 below indicates that you Acknowledge receipt of this Notice:

Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

Date of Last Revision: 2/01/2015

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ACKNOWLEDGEMENT OF (1) RECEIPT OF PRIVACY PRACTICES, (2) RECEIPT OF CONSENT TO TREATMENT AND (3) MY CONSENT FOR ELECTRONIC COMMUNICATION

(1) I hereby acknowledge receipt of a copy of the Healing Center for Change *"NOTICE OF PRIVACY PRACTICES"* and know that I am to ask questions about it if I do not understand it.

Client's Printed Name	Date	Client's/Parent's Signature
Client's Printed Name	Date	Client's /Parent's Signature

(2) I hereby acknowledge receipt of a copy of the Healing Center for Change *"GENERAL INFORMATION, CONSENT TO TREATMENT, AND ACCEPTANCE OF CENTER'S POLICIES"* and accept the terms of treatment discussed in it. I understand that I am to ask my therapist if I have any questions about it.

Client's Printed Name	Date	Client's/Parent's Signature
Client's Printed Name	Date	Client's/Parent's Signature

(3) In case we need to contact you for any reason, please indicate your preferences and give the appropriate information below:

(Do / do not) contact me by phone ______ Preferred No. ______ Secondary No.

(Do/do not) leave a voice message if you miss me ______ At which number?

(Do / do not) contact me by fax ______ Fax number

(Do / do not) contact me by e-mail ______ Email address

Client's Printed Name	Date	Client's/Parent's Signature
Client's Printed Name	Date	Client's/Parent's Signature

The Healing Center for Change, LLC

Client Information Form

Today's Date:________________

Referral Agency/Contact:____**Referral Phone #:** ______________________

Client's name:____________________________________**Date of Birth**____________**Age:**____Gender: ☐ F ☐ M

Ethnicity: ☐ Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐ Native American ☐ Other

Brief reason for seeking treatment: ____

Religious Affiliation (if applicable): __________________________________

Address:______________________________________City:____________________State:______Zip: _________

Home Phone Number__________________________Okay to leave a message? ☐ Yes ☐ No

Cell Phone Number_____________________________ Okay to leave a message? ☐ Yes ☐ No

Emergency Contact Person_____________________________________Relationship to you?___________________

Emergency Contact's Phone Number: ________________________________

RESPONSIBLE PARTY INFORMATION:

Responsible party:_______________________________________Gender:________Date of Birth:______/_____/______

Relation to Client: _____________________

☐ Same address as client: ☐ Different address than the client (if different, please complete address below)

Home Address: _______________________________________

City:____________________________State:_____________Zip: ______________

☐ Same home phone as client ☐ Different home phone: Home: (_____) _______________

Work Phone: (_____)______________Cell Phone: (_____)______________Email: _________________________

INSURANCE INFORMATION ~Please provide insurance card~ (Skip if self-pay)

Policyholder's Name____Policyholder's SSN: - -

Date of Birth / /______Primary Insurance Co. Name _______
____ Insurance Company's Customer Service

Phone # ____

Insurance ID #________________________________Policyholder's Employer: __________________________________

Group #______________________________Co-pay $ ___________ Deductible? ☐ Yes ☐ No

Amount $_________________ Authorization Required? ☐ Yes ☐ No

Authorization # __________________________________ Number of Sessions Authorized ____________

Maximum Number of Sessions Allowed Per Year____________Is the client covered under a secondary insurance policy? ☐ Yes ☐ No

Private Health Insurance ONLY

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to The Healing Center for Change, LLC. and your therapist., 1755 The Exchange SE, Suite 105, Atlanta, GA , 30339

Signature:____Date:_____________________________

CONFIDENTIAL

PRIMARY REASON(S) FOR SEEKING SERVICES:

☐ Anger Management	☐ Anxiety	☐ Coping Skills	☐ Depression	☐ Eating Disorder
☐ Fear/Phobias	☐ Sexual concerns	☐ Sleeping Problems	☐ Addictive Behaviors	☐ Alcohol/Drugs
☐ Hyperactivity	☐ ADHD	☐ PTSD	☐ Oppositional	☐ Truancy
☐ Running Away	☐ Hallucinations	☐ Sexual Abuse	☐ Abuse/Trauma	☐ work/school
☐ Learning difficulties	☐ Social Skills	☐ Legal Issues	☐ Obsessions/Compulsions	

☐ Other Mental Health Concerns (specify): ______________________________

☐ Other Behavioral Concerns (specify): ______________________________

FAMILY HISTORY:

Client's siblings

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
____________	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
____________	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
____________	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
____________	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
____________	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
____________	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good

Others living in household

Name	Age	Gender	Lives	Quality of relationship with the client
____________	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
____________	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
____________	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
____________	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good

Total number of people living in the home: ______________

MEDICAL HISTORY:

Primary Care Physician:______________________**Telephone:**__________

Have any of the following diseases occurred among the client's blood relatives and the client? (client, parents, siblings, aunts, uncles or grandparents) Check those that apply: *C= Client or F=Family*

C F		C F		C F		C F	
☐ ☐	Allergies	☐ ☐	Deafness	☐ ☐	Muscular Dystrophy	☐ ☐	Blindness
☐ ☐	Anemia	☐ ☐	Diabetes	☐ ☐	Nervousness	☐ ☐	Cancer
☐ ☐	Asthma	☐ ☐	Glandular problems	☐ ☐	Perceptual motor disorder	☐ ☐	Cleft lips
☐ ☐	Bleeding tendency	☐ ☐	Heart diseases	☐ ☐	Mental Retardation	☐ ☐	Suicide
☐ ☐	Multiple sclerosis	☐ ☐	High blood pressure	☐ ☐	Seizures	☐ ☐	Migraines
☐ ☐	Cerebral Palsy	☐ ☐	Kidney disease	☐ ☐	Spinal Bifida	☐ ☐	MH
☐ ☐	Sickle Cell	☐ ☐	Cleft palate	☐ ☐	Other (specify):______________		

Client's Current Health: ______________________________

Family Health: ______________________________

List any serious accidents, illnesses, operations or hospitalizations and what year.

____

____

MEDICATION HISTORY:

Pregnant: ☐ Yes ☐ No   Taking birth control: ☐ Yes ☐ No Miscarriage / abortion: ☐ Yes ☐ No

Current/recent medications: Dose (mg) Dates Effective?

______________________________ ☐Yes ☐ No
______________________________ ☐Yes ☐ No
______________________________ ☐Yes ☐ No

Is the client medication compliant? ☐ **Yes** ☐ **No** ☐ **N/A**______________________

Past medications prescribed: ______________________________

Is client allergic to any medication? ☐ Yes ☐ No If Yes to What: ______________________
Is client allergic to anything else? ☐ Yes ☐ No If Yes to What: ______________________

CHEMICAL USE HISTORY:

Does the client use or have a problem with alcohol or drugs? ☐ Yes ☐ No
If Yes, ☐ Methamphetamine ☐ Marijuana ☐ Alcohol ☐ Crack ☐ Prescription Drugs ☐ Cocaine Other______
Length of use:_______________Frequency of use:________________History of use: ______________________
Does anyone in the household use illegal drugs: ☐ Yes ☐ No Who: ______________________

Substance Abuse History Details:______________________________

____

____

COUNSELING/PRIOR TREATMENT HISTORY:

Does client receive other mental/behavioral health services presently: Yes ☐ No ☐ If yes, list other provider(s):

____

Information about client (past and present):

Counseling/Medication Treatment ☐ Yes ☐ No Year:_______Result: ______________________
Drug/Alcohol treatment ☐ Yes ☐ No Year:_______Result: ______________________
Hospitalizations ☐ Yes ☐ No Year:_______Result: ______________________

____

BEHAVIORAL/EMOTIONAL STATUS:

Please check any of the following that are typical for the client:

☐ Aggressive	☐ Frustrated easily	☐ Sad	☐ Selfish	☐ Alcohol issues
☐ Gambling	☐ Angry	☐ Anxiety	☐ Hallucinations	☐ self-injury
☐ Sets fires	☐ Separation anxiety	☐ Hurts animals	☐ Sexual addiction	☐ social problems
☐ Loner	☐ work problems	☐ Sexual acting out	☐ relationship problems	☐ parenting issues
☐ Short attention span	☐ Bizarre behavior	☐ Irritable	☐ Sleeping problems	☐ Lazy
☐ Speech problems	☐ Careless, reckless	☐ fights	☐ Learning problems	☐ Lies frequently
☐ Steals	☐ Clumsy	☐ Suicidal threats	☐ Low self-esteem	☐ Messy
☐ Suicidal Attempts	☐ argumentative	☐ Moody	☐ Tics or twitching	☐ Nightmares
☐ Cyber addiction	☐ Defiant	☐ Destructive	☐ Hyperactive	☐ Phobias
☐ Panic attacks	☐ Drug dependence	☐ Quarrels	☐ Impulsive	☐ Fearful

History of Trauma: ☐**Yes** ☐ **No, If yes, explain:**______________________
☐ Family violence ☐ Living with alcoholic or drug addict

History of Abuse ☐**Yes** ☐ **No** If yes, by whom was client abused: ______________________
Type of abuse: ☐ Physical ☐ Sexual ☐ Emotional ☐ Psychological **Client is:** ☐ Perpetrator ☐ Witness ☐ Victim

Does client engage in situations where high risk is involved? ☐ Yes ☐ No
☐ Unprotected sex ☐ Drinking and driving ☐ Physical fights ☐ Shoplifting
☐ Excessive spending ☐ Other______________________

Have there been any significant changes or events in the client's life? ☐ Yes ☐ No
If yes ☐ family death ☐ moving ☐ fire ☐ other: ______________________

____

EDUCATION:
Current school: ________________________________ Highest Grade Completed: __________

(PLEASE CHECK)____HIGH SCHOOL_____GED______BA/BA_____MA/MS ____PH.D./PSY.D

SOCIAL RELATIONSHIPS:
☐ Follower ☐ Leader ☐ Difficulty making friends ☐ Makes friends easily ☐ Lonely ☐ Has a best friend ☐No friends
☐ dating/married ☐internet ☐ Other ____________________

SUPPORT NETWORKS:
Which community resources is client currently utilizing? ☐ Church ☐ Civic Groups ☐ Social Services Agencies Community
☐ Action Authority ☐ Other: ____

VOCATIONAL/ LEISURE ACTIVITIES:
Does the client work? ☐Yes ☐ No Employer: ___
______________________ How long has client been at current job?
______________________Longest job ever held?______________
What does the client do in his/her leisure time? ______________________________________

LEGAL PROBLEMS:
1. Has the client ever been arrested? ☐ Yes ☐ No ______________________________
2. Is the client presently on probation? ☐ Yes ☐ No______________________________

Please explain legal issues
____
____

The three biggest issues/stressors in my life right now are:

1.____

2.____

3.____

Please provide any additional information that you would like for us to know:

____
____
____
____
____
____
____
____
____

Please briefly describe your overall goals for therapy services:

____
____
____