Paraclete
Counseling Center, Inc.

3905 Johns Creek Court, Suite 260, Suwanee, GA 30024
(770) 753-0350 office (770) 497-9536 fax

INFORMED CONSENT AND AUTHORIZATION

Paraclete Counseling Center, Inc. offers biblically sound, psychologically competent professional counseling for individuals, couples, families and groups. Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order for us to work most effectively together, I ask that you carefully read the information below. If you have any questions regarding the following information, please discuss these with me during your first session.

All counselors operate from some particular moral basis, which may or may not come from a religious perspective. We want to inform you that all the counselors in this office operate from a Judeo-Christian point of view. If you do not wish that to be included as a part of your counseling, please let me know during your first session.

All of our counselors have a minimum of a Master's degree in counseling, marriage & family therapy or other related field. The counselors in this office all have a license in the state of Georgia. We abide by the ethical guidelines of the ACA, AMHCA and the AACC.

BENEFITS AND RISKS OF THERAPY:

There are some risks as well as many benefits with therapy. For example, in therapy, there is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. Clients may recall unpleasant memories. Sometimes a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives.

While you consider these risks, you should know also that scientists in hundreds of well-designed research studies have shown the benefits of therapy. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems are solved. Please note that there are no guarantees that you will get better as a result of participating in therapy. I encourage you to be an active participant in your therapy and collaborate with me to create and achieve your goals. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I 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, I will direct you to other resources that will be of assistance to you.

When you enter into counseling, you are forming a therapeutic professional relationship with me that is different than other social relationships you have. There may be times in which you may see me in social settings other than the therapy setting. In other such settings you may experience a dual relationship with me. A dual relationship refers to any situation where multiple roles exist between a therapist and a client. If you see me in another social situation, I will only interact and speak with you if you first initiate contact with me. If you do not initiate contact with me, then I will not initiate any conversation with you.

If you have a dispute or complaint with me as your therapist, I encourage you to come to me first to discuss the complaint. If we cannot resolve it, then I encourage you to discuss the issue with the center director to try to resolve the dispute.

CONFIDENTIALITY:

All information shared between counselor and client is confidential and privileged and will not be revealed unless required by law in such cases of suspected child abuse or threats of physical harm to self or others.

There are two situations in which I might talk about your case with another therapist. When I am out of the office or am not "on call", another therapist in this office will be available to you in emergencies. Therefore, this therapist needs to know about you. Generally, I will tell this therapist only what he or she needs to know about you to help you in an emergency. Second, in order to give high quality treatment, I sometimes consult with other professionals about my clients. The same rules and laws that I am bound by also bind these professionals in order to protect your confidentiality.

In the course of treatment, it is necessary for me to contact you. Please check which forms of communication we may use (one of these must be a phone number):

□ Phone numbers _____
_____ Initial here if it is okay to leave message

□ Email _____

Sometimes it will be necessary for me to contact you or a family member in the case of life and death situations. In these situations, I ask you to provide me with the name and number of a contact person so I may contact them in certain life or death situations. Name of contact person _____
Phone number _____
By initialing here_____ you give me permission to contact this person only in the event of a life or death emergency.

In non-emergency situations, please leave me a message on my confidential voicemail by calling 770-753-0350. My extension is _____.

PAYMENTS AND BILLING:

Therapy Sessions: Most therapy sessions last 50 minutes. If you require a longer or shorter session, it will be prorated based on your fee. Any client who has a balance of fees for more than two sessions will be unable to continue therapy until your payment is made. Individual exceptions can be made through your individual therapist. If you are unable to pay these fees, please talk to me about this to make other arrangements. Please remember that final payment of your bill is your responsibility NOT your insurance company. In the event that we are unable to collect fees owed by you, we reserve the right to use an outside collection agency to work on our behalf to collect overdue balances.

Initial Session	$130
Family/Couples	$100
Individuals	$100
Addiction Assessment	$250

(Initial Session, Testing, Reports & Phone Interview with significant other)

Cancellation of Appointment: If you must cancel your appointment, please call the office and leave a message on my voicemail. **You must cancel at least 24 hours in advance of your scheduled appointment.** If you do not cancel your appointment **24 hours in advance**, you will be charged our standard fee, not your co-pay _____ (Initial here). Insurance does not cover late cancellations or no shows. Exceptions will be made in case of illness or other emergency. Your cooperation in this matter is greatly appreciated.

Telephone Consultations: I understand that at times telephone consultations are necessary. If a conversation lasts over 10 minutes, please see the fee breakdown below.

10-20 minutes	20-30 minutes	35-50 minutes
$25	$50	$100

Court/Legal Testimony: The counselors in this practice are not trained in forensic psychology, and therefore rarely give court testimony. If you believe that court testimony may be necessary, please discuss this with me in your first session. If you subpoena me to court and I must cancel my regular schedule to be available for court, you will be charged $1500 per day. If I have cleared my schedule for court, I need 48 hours notice for cancellation of court appearance or you will be charged $1500.

Reports: I will not charge you for my time spent making simple reports to your insurance company. However, any reports needed for other professionals, including but not limited to lawyers, courts, other medical doctors, and school officials, will be charged a fee, please see the fee breakdown below.

10-20 minutes	20-30 minutes	35-50 minutes
$25	$50	$100

Testing: At times I may find it necessary to have you complete an assessment to help better evaluate your situation. Some of these cases include but are not limited to depression, anxiety, marital therapy, addiction, etc. These assessments will be discussed with you prior to that time and fees will be discussed then. Assessments range in price from $10-$90.

Unpaid Balances: If you have an unpaid balance, no records, test results or evaluations will be released until the balance is paid in full. _____ (Initial here)

Returned Checks: If your check is returned with Non Sufficient Funds, you will be assessed a $30 fee.

USE OF TECHNOLOGY IN THE THERAPY PROCESS:

I understand that there are many forms of technology available to us for communication. Please know that I cannot guarantee the safety of cell phone conversation or texting. I also cannot guarantee the safety of email. Email through Paraclete Counseling Center is not encrypted. Therefore, I ask you to limit your email for the purposes of scheduling appointments. If you choose to send therapeutic content in an email, I cannot guarantee the confidentiality of this information. Please know that copies of texts or email will be printed and put in your file. The policy of Paraclete Counseling Center is that therapists are not allowed to be a "friend" on Facebook with clients. We have a business Facebook page, so you can "like" the Paraclete Counseling Facebook page. If you choose to "like" our page, please know that others might assume you have some professional relationship with us.

TERMINATION:

The best way of terminating therapy is to complete a plan with me that brings the therapy process to a close. The professional therapeutic relationship between you and me will be considered terminated if there has been no face to face psychotherapy for a period of 90 days _____ (Initial here). It is our standard office procedure to send a letter documenting termination to the address provided in your intake information.

IN CASE OF EMERGENCY:

In the event you have a life-threatening emergency, please call 911 or go to your nearest emergency room or call GA Crisis & Access Line @ 1-800-715-4225.

I have read and understand the conditions and information above and give authorization to begin treatment.

_____ _____
Signature of client or parent Date

_____ _____
Signature of therapist Date

IMPORTANT EXTENSIONS:

New Clients	Option 2		
Lisa Poore/Director	102	Kim Hart/Operator	101 or 0
Heather Cobb	103	Terry Kinton	110
Troy Snyder	104	Cliff Hamilton	160
Pat Caffrey	105	Directions to Office	Option 4
Rich Oswald	107	Off. Address & Fax#	Option 5
Adam Bagley	108		
Kami Legg	109		

A copy of this form will be kept in your confidential file. If you wish to have a copy for your records, please request one.
rev. 1/13

Paraclete
Counseling Center, Inc.

This form will enable us to gain a quicker understanding of you and it will become a part of your confidential file. Please answer each question as completely as possible. If you are a couple, please fill out two forms, one for each person.

Date_____

Name_____ Age_____ Sex _____
First Middle Last

Address_____

_____
City State Zip

Home Phone _____ Work Phone _____

Cell Phone _____ Date of birth _____

Marital Status (Circle one): Single Engaged Married(# of years ____) Widowed Separated Divorced(How long? ____)

Occupation_____ Total hours/week_____

Employer (or school) _____ Full-time Part-time

Address of employer _____

Primary Care Physician (PCP) _____

Address _____ Phone _____

Family member to notify in case of emergency _____

Emergency contact phone number _____

Who gave you my name? _____

May I have your permission to thank this person for your referral? Yes No

Would you like to receive information regarding upcoming events and groups offered by Paraclete? Yes No
If yes: (Email)_____

Do you expect to be involved in any legal action where your counselor's documentation or testimony will be required?

Please explain. _____

_____

Concerns Check List

___Anger
___Fearfulness
___Physical problems
___Problem with parents
___Trouble making decisions
___Work
___Cutting or burning self
___Depression
___Nervousness
___Social relationships
___Spiritual concerns
___Unhappy most of the time
___Grief
___Sleep Issues
___Education
___Financial problems
___Problems with children
___Sexual concerns
___Use of alcohol
___Worry
___Other (Specify) _____
___Eating difficulties
___Marital problems
___Abuse
___Thoughts of suicide
___Use of other drugs
___Thought of harming someone else

Suicidal/Homicidal Ideation

Have you ever attempted to commit suicide or homicide *in the past*? _____

If yes, how? _____

Is there a history of suicide in your nuclear and/or extended family? _____

Recent Losses (Please circle all that apply)

Family Health Disruption in lifestyle Job Significant other Other _____

Psychiatric History (Please list any previous inpatient and outpatient counseling and/or addiction treatment experiences)

Place	Dates	Length of Time	Inpatient or Outpatient	Reason

Name of current psychiatrist _____

List all medications you have taken *in the past* for anxiety, depression, and/or sleep

_____

Medical Information

Describe any current medical condition _____

Height _____ Weight _____

Please list the name of the medication, dosage, frequency, prescribing physician and the date started (or attach a list).

Medication/Supplement	Dosage	Frequency	Prescribing Physician	Start Date

Date of your last physical exam including blood test? _____ Have you ever had an abortion? _____

Describe any sleep problems you have: _____

Do you have any allergies? _____, If so, list them_____

Please list any previous health problems, operations and medical hospitalizations:

_____

Substance Abuse History

Describe your current usage or usage within the past year of the following:

	First Use	Last Use	Average Amount	Frequency of use
Alcohol				
Marijuana				
Caffeine				
Meth				
Cocaine				
Heroin				
Pain Medication				
Morphine				
Nicotine				
Pornography				
Gambling				
Other _____				

Have you experienced a *recent increase* in the use of alcohol and/or other substances?_____

Do you see your current usage as a problem? _____

Is there a history of alcohol and substance abuse in your family? _____, If so, who?_____

Nutrition

Have your eating habits changed recently? Yes No

Has your weight fluctuated more than 10lbs. +/- over the previous year? Yes No

Do you often eat out of depression, boredom, and anger? Yes No

Do you ever self-induce vomiting? Yes No

Do you ever binge eat or feel your eating is out of control? Yes No

Do you use laxatives, water pills, or diet medications? Yes No

How do you feel about eating with others in a group? _____

Legal History (Please circle all that apply)

Charges as a minor Charges presently Arrests Incarcerations Parole Convictions

Probation Bankruptcy Civil suit DUI Other _____

Developmental History

List members of your family that you grew up with

_____ _____ _____

_____ _____ _____

What was your birth order? ____of ____ children Who primarily raised you? _____

How would you describe your childhood? Traumatic Painful Uneventful Positive

What were you like as a child (include friends, school, hobbies, and personality)? _____

_____

_____

What is your sexual orientation? Heterosexual Homosexual Bisexual

Support System

Who can you count on for support? _____

Who are you currently living with? _____

Financial Situation

Describe briefly your financial situation _____

Marital History (if applicable)

Previous marriage? Yes No If yes, date of divorce _____

What is your perception of your current marriage (include communication patterns, problems, sexual relations)

_____

_____

Religious/Cultural Factors

What is your ethnic/cultural background?_____

What is your religious background? _____

Do you currently attend church, synagogue or mosque? Yes No ACTIVE INACTIVE

If yes, please list where you attend._____

Work History

Describe your current job/career _____

Would you enjoy doing this job on a long-term basis? _____

If you could have any job/career, what would you choose? _____

How do you deal with authority figures? _____

Describe your relationship with co-workers _____

Describe your job performance _____

Have you ever been fired? Yes No If yes, explain _____

How many jobs have you held within the previous five years? _____

Were you ever in the military? _____

Educational History

Highest level achieved _____ What type of grades did you make? _____

Are you currently in school? Yes No If yes, what level? _____

Family

Spouse's Name_____ Age _____ Birthdate _____

Children

Name	Age	Living with you (y/n)	Biological, Step, Adopted or Foster?	Custody

Would it be beneficial for any members of your family to be involved in your treatment? Yes No

If yes, explain_____

_____

Is there anything else you feel that we need to know about you? Yes No

If yes, please explain_____

_____

_____

Revised 5-2010

FINANCIAL INFORMATION SHEET

If you have any financial questions or concerns about your fee, please talk to your therapist. Fees or co-pays are due at time of service. You may use cash, check, debit cards, Visa, MasterCard or Discover.

PART A

Total gross family income _____ # of dependents_____

Who is financially responsible for these fees? _____

Do you have insurance? _____

If your therapist is a contracted provider with your insurance company, we will file all claims. If the therapist is **not** a contracted provider, we will verify whether you have out-of-network benefits. If you do, we will file for you; and you will be responsible for all deductibles and co-pays. If you do not, no claims will be filed; and you will be responsible for all fees at the time of service.

ALL BLUE CROSS/BLUE SHIELD CLIENTS MUST FILE THEIR OWN CLAIMS. BLUE CROSS/ BLUE SHIELD WILL ONLY REIMBURSE THE INSURED NOT NON-NETWORK PROVIDERS.

PART B

Is your therapist a part of your managed care plan? ___Yes ____No ____I Don't Know

Primary Insurance Company _____

Address _____

Phone Number of Insurance Company _____

Policy #_____ Group # _____

Insured's Name _____ Insured's SS# _____

Insured's Date of Birth _____

Insured's Employer _____

I, the undersigned, do authorize the release of any medical information necessary to process claims. I hereby assign payments directly to Paraclete Counseling Center and the supervisors thereof of the benefits as well as major medical benefits herein specified, and otherwise payable to me under the terms of my insurance. I understand that I am financially responsible to the clinician for charges not covered by this agreement. I hereby authorize photocopies of this form to be as valid as the original. Signed this _____ day of _____, 20_____; in the city of _____, situated in _____ county, state of Georgia.

Signed_____ Date _____

Revised 9-2010