



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	\$110
Individuals	\$110
Addiction Assessment	\$375
(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.

<u>10-20 minutes</u>	<u>20-30 minutes</u>	<u>35-50 minutes</u>
\$30	\$55	\$110

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.

<u>10-20 minutes</u>	<u>20-30 minutes</u>	<u>35-50 minutes</u>
\$30	\$55	\$110

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-\$100.

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	April Miller/Operator	101 or 0
Heather Cobb	103	Christie Poole	110
Troy Snyder	104	Cliff Hamilton	116
Pat Caffrey	105	Directions to Office	Option 4
Rich Oswald	107	Off. Address & Fax#	Option 5
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. 03/14

Who has legal custody? Mom _____ Dad _____ Joint _____ Other _____

Who has physical custody? Mom _____ Dad _____ Joint _____ Other _____

Stepparent's name _____ Birthdate _____

Address _____ Home phone _____

Employer _____ Work phone _____

Who gave you our name? _____

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

Religious Affiliation _____ Church _____

Parents Active _____ Inactive _____ Child Active _____ Inactive _____

Part III: Financial

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? _____

Is your therapist an in-network provider for your insurance company? Yes No Don't Know

If your therapist is in your network, we will file all claims. If your therapist is out-of-network, we will file claims only if you have out-of-network benefits.

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 _____

Psychosocial History

Part IV: Development

Please fill in any information you have on the areas listed below.

Prenatal medical illnesses and health care _____

Was the child premature? _____ Any birth complications or problems? _____

In the first few months of life, please list any problems in the following areas.

Any allergies? _____

Sleep patterns or problems _____

Personality _____

Does your child have any speech, hearing, or language difficulties? _____

Please describe any special classes that your child has attended or currently attends _____

Part V: Health

List any major childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures and other medical conditions. Please list the condition, age, and consequences _____

Part VI: Residences

1. Homes - please list all dates that the child has lived in different residences, including location, who they were living with, their reason for moving, and any problems.

2. Residential placements, institutional placements, or foster care - if applicable, please list dates that the child was placed in a home, the program and location, the reason for the placement, and any problems.

Part VII: Schools

Please list all of the schools the child has attended, including grades. Please list the current grade, school, and teacher.

Part VIII: Special skills or talents of child

List hobbies, sports, recreational interests, TV, and toy preferences, etc. _____

Part IX: Other

Is there anything else I should know that doesn't appear on this or any other forms, but might be important? _____

Symptom Checklist

Below you will find statements about your child and any symptoms he or she may be experiencing. Circle the number below the word that best describes your child's behavior during the last 3 months. Please write under the statement any additional information that you feel would be helpful.

Personal-Social

	Never	Sometimes	Often	Always
1. My child continually seeks attention.	0	1	2	3
2. I can see tension building up in my child.	0	1	2	3
3. My child explodes under stress.	0	1	2	3
4. My child has nervous habits, like pulling at his/her clothing, clearing his/her throat, sniffing his/her nose, etc.	0	1	2	3
5. My child cries easily.	0	1	2	3
6. My child sucks his/her thumb or finger.	0	1	2	3
7. My child is a worrier.	0	1	2	3
8. My child rocks back and forth.	0	1	2	3
9. My child shakes and trembles.	0	1	2	3
10. My child expresses many or unusual fears.	0	1	2	3
11. My child is angry.	0	1	2	3
12. My child is moody.	0	1	2	3

	Never	Sometimes	Often	Always
13. My child becomes overexcited easily.	0	1	2	3
14. My child is hyperactive and restless.	0	1	2	3
15. My child becomes hysterical, upset, or angry when things do not go his/her way.	0	1	2	3
16. My child seems sad.	0	1	2	3
17. My child has sleep problems.	0	1	2	3
18. My child has bad dreams.	0	1	2	3
19. My child walks or talks in his/her sleep. (underline one or both)	0	1	2	3
20. My child gets confused easily.	0	1	2	3
21. My child has trouble remembering things.	0	1	2	3
22. My child has difficulty concentrating for any length of time.	0	1	2	3
23. My child complains he/she never gets a fair share of things.	0	1	2	3
24. My child says people don't like him/her.	0	1	2	3

	Never	Sometimes	Often	Always
25. My child tends to be very selfish and self-centered.	0	1	2	3
26. My child is very shy.	0	1	2	3
27. My child is sensitive and has his/her feelings hurt easily.	0	1	2	3
28. My child avoids competition.	0	1	2	3
29. My child is a poor sport and a poor loser.	0	1	2	3
30. My child has trouble making friends.	0	1	2	3
31. My child seems to have little self-confidence.	0	1	2	3
32. My child cannot get along with my husband/wife.	0	1	2	3
33. We have family problems.	0	1	2	3
34. There is a lot of arguing and fighting in our house.	0	1	2	3
35. My child expresses concerns about something terrible or horrible happening to family members or himself/herself.	0	1	2	3
36. My child does not get along with his/her siblings.	0	1	2	3
37. My child expresses strong dislike for home and family.	0	1	2	3

	Never	Sometimes	Often	Always
38. One (or more) of my children has problems, also.	0	1	2	3
39. My child says strange things or asks unusual questions.	0	1	2	3
40. My child does strange or stupid things.	0	1	2	3
41. My child often says he/she wishes he/she were dead or away from it all.	0	1	2	3
42. My child has been physically or sexually abused.	0	1	2	3
43. My child often has small accidents or injuries.	0	1	2	3
Behavioral				
44. My child is a discipline problem at home.	0	1	2	3
45. My child is a discipline problem at school.	0	1	2	3
46. My child tells tall tales or lies.	0	1	2	3
47. My child often throws temper tantrums.	0	1	2	3
48. My child has attempted to seriously harm a person or animal.	0	1	2	3
49. My child manipulates situations to his/her own benefit.	0	1	2	3
50. My child does sexual things he/she shouldn't.	0	1	2	3
51. My child seems to welcome punishment.	0	1	2	3

	Never	Sometimes	Often	Always
52. My child disturbs other children by teasing, provoking fights, and interrupting others.	0	1	2	3
53. My child steals things.	0	1	2	3
54. I have to spank my child.	0	1	2	3
School				
57. My child voices an intense dislike of school.	0	1	2	3
58. My child does not seem to be learning, as he/she should.	0	1	2	3
59. The teachers complain about my child.	0	1	2	3
64. My child stares blankly into space and is unaware of his/her surroundings when doing so.	0	1	2	3
68. My child often complains of illnesses such as nausea, stomach pain or headaches.	0	1	2	3
69. My child sometimes has accidental bowel movements in his/her clothing.	0	1	2	3
70. My child has eating problems.	0	1	2	3
71. My child wets the bed.	0	1	2	3

Please circle YES or NO to the following statements as it pertains to your child.

Physical

60. My child's bowels move regularly. YES NO

61. My child is overweight or underweight. YES NO

(underline which one applies)

63. My child has had a major illness, operation YES NO

or accident (such as a fall or bump on the

head). If yes, please list_____

School

55. My child is in a special program at school. YES NO

56. My child may have a learning disability. YES NO

65. My child has a visual, hearing, or speech problem. YES NO

66. My child has allergies or asthma. YES NO

67. My child has a chronic illness or handicap. YES NO

Revised 3/14