



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**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Anger                    | <input type="checkbox"/> Depression               | <input type="checkbox"/> Education              | <input type="checkbox"/> Eating difficulties             |
| <input type="checkbox"/> Fearfulness              | <input type="checkbox"/> Nervousness              | <input type="checkbox"/> Financial problems     | <input type="checkbox"/> Marital problems                |
| <input type="checkbox"/> Physical problems        | <input type="checkbox"/> Social relationships     | <input type="checkbox"/> Problems with children | <input type="checkbox"/> Abuse                           |
| <input type="checkbox"/> Problem with parents     | <input type="checkbox"/> Spiritual concerns       | <input type="checkbox"/> Sexual concerns        | <input type="checkbox"/> Thoughts of suicide             |
| <input type="checkbox"/> Trouble making decisions | <input type="checkbox"/> Unhappy most of the time | <input type="checkbox"/> Use of alcohol         | <input type="checkbox"/> Use of other drugs              |
| <input type="checkbox"/> Work                     | <input type="checkbox"/> Grief                    | <input type="checkbox"/> Worry                  | <input type="checkbox"/> Thought of harming someone else |
| <input type="checkbox"/> Cutting or burning self  | <input type="checkbox"/> Sleep Issues             | <input type="checkbox"/> Other (Specify) _____  |  |

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 \_\_\_\_\_

## 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



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Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Spouse's Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

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If yes, explain \_\_\_\_\_

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### 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



**Addendum to Informed Consent**

I understand that if I am being seen in the context of marriage or family counseling that my medical note will have information about multiple parties contained in it. If in the event that a couple or family members become involved in legal matters against one another, none of the parties involved in counseling can have copies of the record without all parties giving written consent.

I understand that the therapists at Paraclete Counseling Center do not have training in forensic psychology, and therefore are not qualified to offer opinions for legal testimony. I agree that I will not ask my therapist to provide any legal affidavit. Furthermore, I agree not to subpoena my therapist for legal testimony. By signing below, you are agreeing to abide by this policy.

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Signature

---

Date

---

Signature

---

Date

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



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	\$400
(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 \$40-110.

**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	Kami Legg	109
Heather Cobb	103	April Miller	101 or 0
Troy Snyder	104	Directions to Office	Option 4
Pat Caffrey	105	Office Address/Fax#	Option5
Sanona Williams	106		
Danielle Olowoyo	107		
Sylvain Panu	108		

**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. 9/16**

: