PATIENT INTAKE PAPERWORK CHECKLIST

1. COMPLETE PATIENT PROFILE INFO (PATIENT ALLY) _____
2. ARTICLE: THERAPIST SPILL _____
3. INITIAL INTAKE INFORMATION _____
4. HIPPA PRIVACY SIGNED _____
5. PATIENT'S RIGHTS SIGNED _____
6. FINANCIAL POLICY SIGNED _____
7. MINOR AGREEMENT FOR MINORS IN THERAPY _____
8. ADVANCED DIRECTIVES SIGNED _____
9. LIMITS OF CONFIDENTIALITY SIGNED _____
10. SIGNATURE ON FILE SIGNED _____
11. ACKNOWLEDGEMENT OF RECEIPT SIGNED _____
12. SCREENING FORMS COMPLETED _____
13. COPY OF DRIVERS LICENSE _____
14. COPY OF INSURANCE CARD _____
15. RELEASE OF INFORMATION _____
16. CONSENT TO TREATMENT _____
17. OBTAIN AUTH # FROM INSURANCE IF NEEDED _____
18. EMAIL VERFICATION OF MENTAL HEALTH BENEFITS AND COVERAGE OF INSURANCE FOR 2013 _____
    Email: dmorris799@cs.com or Fax: 678-732-0349

Therapists Spill: 8 Ways Clients Spoil Their Progress in Therapy (& How to Change That)

By MARGARITA TARTAKOVSKY, M.S.

Therapy can be tremendously effective.

But sometimes as clients, we can stand in our own way. In fact, we might unwittingly hinder the therapeutic process and spoil our progress.

Below, clinicians share eight actions that typically prevent clients from getting the most out of therapy — and what you can do.

1. A poor fit between clinician and client. It's common — and recommended — to try out several clinicians before making your decision. According to Ryan Howes, Ph.D, a clinical psychologist and professor in Pasadena, California, "It's important to check a potential therapist's license and credentials, their areas of expertise, the logistical factors [such as] cost, distance [and] insurance, and then test drive a handful of therapists before selecting one." While it might feel uncomfortable telling a therapist you don't want to work with them, remember that the right fit is important for your progress. "If you don't feel safe opening up to this person, you're not likely to meet your goals," Howes said.

2. Not asking questions. Do you know what your diagnosis means? What your goals are in therapy? What you need to do in between sessions? Many clients don't ask their therapist questions, Howes said. "[Clients don't ask] because they feel intimidated, or believe it wouldn't be polite, or can't get a word in edgewise," he said. "Instead, they go home and ask their friends what the therapist meant when she said _____." Howes encouraged readers to ask questions any time you need clarification.

3. Being inconsistent. "Therapy is hard work," said Alison Thayer, LCPC, CEAP, a psychotherapist at Urban Balance, LLC. And there are many obstacles and responsibilities that can easily get in the way. But consistency is key in therapy, she said. "Clients must understand that therapy is going to take time and commitment, and in order to maximize the benefits, they need to make sessions a priority," she said.

4. Not doing the work outside of sessions. Change doesn't just happen in session. It happens outside the therapist's office. But "some clients seem to leave the session, get swept up in the busyness of the week, and then show up a week later having spent no time thinking about our work together," Howes said. "Progress is slow to none at this rate." What does promote progress is when therapy lasts all week, Howes said. In other words, "you're applying what you've learned in therapy on a daily basis and you're noticing topics you'd like to cover in the next session." Thayer added: "While the sessions are important, so are the clients' efforts to reflect [on] therapeutic content and make changes in their lives."

5. Ditching therapy because of discomfort. At times therapy can be unpleasant, Howes said. "The subject matter you're discussing, the blockages you're working through, or challenges within the therapeutic relationship can make you wonder why you're dedicating time and money to this unpleasantness," he said. Such discomfort can lead clients to consistently arrive late to sessions, said clinical psychologist John Duffy, Ph.D. Or some clients simply "cut and run," Howes said. Rather than leaving, however, Howes suggested sharing your feelings with your therapist. "Together, the two of you might find a different pace or approach that isn't quite as painful," he said.

6. Expecting a quick fix. "Sometimes, clients may have a preconceived idea that they want to resolve an issue in a certain number of sessions," Thayer said. But this kind of thinking can limit your experience in therapy, she said. "Because every client and presenting issue is unique, there is not necessarily a set, prescribed number of sessions that can guarantee positive results," she said. That's why she suggested clients keep an open mind about how quickly they improve.

7. Expecting the therapist to do all the work. "Therapy is an active process and requires work on the part of the therapist and the client," said Julie Hanks, LCSW, a therapist and blogger at Psych Central. "Clients who expect their therapist to work harder or invest more in treatment than they are willing to invest in themselves usually don't get the maximum benefit of therapy," she said.

8. Reenacting the same patterns. "Clients will generally use the same defense mechanisms and tactics in the therapy process that led them to seek therapy in the first place," Hanks said. For instance, a client who has a tough time asserting her needs and puts others first might be habitually late to sessions, thereby depriving "herself of getting her own needs met in therapy," she said.

ADVANCED COUNSELING SERVICES

TRANSFORMING LIVES THROUGH EMPOWERMENT AND LIBERATION

465 Winn Way

Suite 150

Decatur, GA 30030

678-732-0435

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: (_____)_____ May we leave a message? □Yes □No

Cell/Other Phone: (_____)_____ May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

□ Yes

□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?

□ Yes

□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe? _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

Advanced Counseling Services
PRIVACY NOTICE

GEORGIA NOTICE FORM
Notice of Advanced Counseling Services' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Advanced Counseling Services may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment, and Health Care Operations*"
  - ~ *Treatment* is when Advanced Counseling Services' provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when Advanced Counseling Services consults with another health care provider, such as your family physician or another psychologist.
  - ~ *Payment* is when Advanced Counseling Services obtains reimbursement for your healthcare. Examples of payment are when Advanced Counseling Services disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - ~ *Health Care Operations* are activities that relate to the performance and operation of Advanced Counseling Services' practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within Advanced Counseling Services' office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of Advanced Counseling Services' office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Advanced Counseling Services may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission beyond the general consent that permits only specific disclosures. In those instances when Advanced Counseling Services asked for information for purposes outside of treatment, payment and health care operations, Advanced Counseling Services will obtain an authorization from you before releasing this information. Advanced Counseling Services will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes Advanced Counseling Services have made about our conversation during a private, group, joint, or family counseling session, which Advanced Counseling Services have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) Advanced Counseling Services has relied on that authorization; or (2) if the authorization was

obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Advanced Counseling Services may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If DFFC, in a professional capacity, has reasonable cause to believe that a minor or child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, Advanced Counseling Services must immediately report such condition to the Fulton County Department or Family and Children Services.
- **Adult and Domestic Abuse:** If Advanced Counseling Services has reasonable cause to believe that an elderly person (age 60 or older) is suffering from or has died as a result of abuse, Advanced Counseling Services must immediately make a report to the proper authority.
- **Health Oversight:** The Secretary of State – License Board has the power, when necessary, to subpoena relevant records should Advanced Counseling Services be the focus of an inquiry.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and Advanced Counseling Services will not release information without written authorization from you or your legally-appointed representative, or a court order. An effort will be made to inform you in advance if this is the case. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If your counselor determines, or pursuant to the standards of his/her intended profession should determine, that you present a serious danger of violence to yourself or another, he/she may disclose information in order to provide protection against such danger for you or the intended victim.
- **Worker's Compensation:** If you file a workers' compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division of Worker's Compensation.

IV. Patient's Rights and Provider's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Advanced Counseling Services is not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternate Means and at Alternate Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternate locations. (For example, you may not want a family member to know that you are receiving treatment at Advanced Counseling Services. On your request, this member will not be contacted. Upon your request, Advanced Counseling Services will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Advanced Counseling Services may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, Advanced Counseling Services will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Advanced Counseling Services may deny your request. On your request, Advanced Counseling Services will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have provided neither consent nor authorization (as described in Section III of this Notice). On your request, Advanced Counseling Services will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from Advanced Counseling Services upon request, even if you have agreed to receive the notice electronically.

Provider's Duties:

- Advanced Counseling Services is required by law to maintain the privacy of PHI and to provide you with a notice of Advanced Counseling Services' legal duties and privacy practices with respect to PHI.
- Advanced Counseling Services reserves the right to change the privacy policies and practices described in this notice. Unless Advanced Counseling Services notifies you of such changes, however, Advanced Counseling Services is required to abide by the terms currently in effect.
- If Advanced Counseling Services revises policies and procedures, Advanced Counseling Services will mail you a copy of any revisions.

V. Complaints

If you are concerned that Advanced Counseling Services has violated your privacy rights, or you disagree with a decision Advanced Counseling Services made about access to your records, you may contact Delores Morris, M.A., LPC, at (404) 438-2294.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 1, 2006.

Advanced Counseling Services reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that Advanced Counseling Services maintain. Advanced Counseling Services will provide you with a revised notice by mail.

OUTPATIENT TREATMENT SERVICES

PATIENT'S RIGHTS STATEMENT

When you receive services from any healthcare provider, your rights are protected by the Rules and Regulations contained in Chapter 290-4-9. A full copy of the Rules is available to you where ever you receive services. Below is a simplified outline of those rights. The Rules and Regulations describe any limitation to these rights and other provisions which may apply and should be consulted when there is a dispute or question regarding any of these rights.

Your rights include:

1. The right to receive care suited to your needs.
2. The right to receive services that respect your dignity, and protect your health and safety.
3. The right to be informed of the benefits and risks of your treatment.
4. The right to participate in planning your own program.
5. The right to refuse service, unless your provider feels that refusal would be safe for you or others.
6. The right to prompt and confidential services even if you are unable to pay.
7. The right to review and obtain copies of your records, unless the provider or other authorized staff feels it is not in your best interest.
8. The right to exercise all civil, political, personal, and property rights to which you are entitled as a citizen.
9. The right to remain free of physical restraints or time-out procedures unless such measures are required for providing effective treatment, or protecting the safety of you or others.
10. The right to be free of physical and verbal abuse.
11. The rights, if you are residential patient, to converse privately, to have reasonable access to a telephone, to receive and send mail, to have visitors, and to retain your physical effects and money.
12. The right to file a compliant if you think any of your rights have been violated or denied.

If you would like a copy of the summary of patient's Rights Complaint Process, it is available to you upon request.

_____ _____

Patient/Guardian or Parent of a Minor Signature Date

_____ _____

Therapist Signature Date

FINANCIAL POLICY

As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all patients. The financial policy of the Practice is designed to clarify the payment policies as determined by the management of the Practice.

As a service to you, the Practice will bill your insurance companies and other third-party payers, but we cannot guarantee they will reimburse for services rendered. In some cases insurance companies or other third-party payers may consider certain services as a non-medical necessity and therefore not covered by your policy. This means that you or the person who signed for services may end up being responsible for payment of these services. Patients are responsible for payments regardless of the determinations made by your insurance carrier. Patients are also responsible for payment without knowledge of insurance lapses.

Deductibles and co-payments are due at the time of service. Please verify your insurance coverage prior to arriving for your appointment. It is still your responsibility to obtain this information regardless of the information provided by the front desk staff. It is also your responsibility to make sure your policy is active prior to receiving services. Insurance lapses or expired will result in payment by patient.

All insurance benefits will be assigned to the Practice unless the patient prefers to pay out of pocket for services. Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate determined by your therapist. Payment methods include check, cash, credit card, or debit card. Clients using charge cards may either use their card at each session or sign a document allowing the Practice to automatically submit charges to the charge card after each session. Or go to our website for faster service.

Questions regarding the financial policies can be answered by the Office Manager.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: _____ Date: / /

Office Staff Witness: _____ Date: / /

AGREEMENT REGARDING MINORS IN THERAPY

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Very often, it is best to see them with parents and other family members; sometimes, they are best seen alone. I will assess which might be best for your child and make recommendations to you. Obviously, the support of all the child's caregivers is essential, as well as their understanding of the basic procedures involved in counseling children.

The general goal of involving children in therapy is to foster their development at all levels. At times, it may seem that a specific behavior is needed, such as to get the child to obey or reveal certain information. Although those objectives may be part of overall development, they may not be the best goals for therapy. Again, I will evaluate and discuss these goals with you.

Because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.

The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, at the same time that parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and of the child in therapy.

This agreement regarding treatment of minors has provisions for inserting individual details, which can be supplied by both the child and the adults involved. However, it is first important to point out the exceptions to this general agreement. The following circumstances override the general policy that children are entitled to privacy while parents or guardians have a legal right to information.

- Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible.

- Minors may independently enter into therapy and claim the privilege of confidentiality in cases involving abuse or severe neglect, molestation, pregnancy, or communicable diseases, and when they are on active military duty, married, or officially emancipated. They may seek therapy independently for substance abuse, danger to self or others, or a mental disorder, but parents must be involved unless doing so would harm the child. *(These circumstances may vary from state to state, and the specific laws of each state must be followed.)*

- Any evaluation, treatment, or reports ordered by, or done for submission to a third party such as a court or a school is not entirely confidential and will be shared with that agency with your specific written permission. Please also note that I do not have control over information once it is released to a third party.

Now that the various aspects surrounding confidentiality have been stated, the specific agreement between you and your child/children follows:

I, (name) _____ (relationship to child) _____

I, (name) _____ (relationship to child) _____

agree that my/our child/children

(name) _____

(name) _____

should have privacy in his/her/their therapy sessions, and I agree to allow this privacy except in extreme situations, which I will discuss with the therapist. At the same time, except under unusual circumstances, I understand that I have a legal right to obtain this information.

I will do my best to ensure that therapy sessions are attended and will not inquire about the content of sessions. If my child prefers/children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Basically, unless my child has/children have been abused or is/are a clear danger to self or others, the therapist will normally tell me only the following:

- whether sessions are attended
- whether or not my child is/children are generally participating
- whether or not progress is generally being made

The normal procedure for discussing issues that are in my child's/children's therapy will be joint sessions including my child/children, the therapist, and me and perhaps other appropriate adults. If I believe there are significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/children present. Similarly, when the therapist determines that there are significant issues that should be discussed with parents, every effort will be made to schedule a session involving the parents and the child/children. I understand that if information becomes known to the therapist and has a significant bearing on the child's/children's well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

Parent(s): Please make any additions or modifications as desired: _____

_____

_____

Signature: _____ Date: _____

Minor(s): Please make any additions or modifications as desired: _____

_____

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____T.

ADVANCED DIRECTIVES

I, _____ am aware that all health maintenance, medical, and mental health treatment contain an element of risk for an adverse reaction. During the course of my treatment, in the event that I lose consciousness, or become unable to respond in such a way as to pose a serious life threatening emergency, I will be transported to the nearest emergency care facility.

_____While at the Emergency Care Facility, if I am still unable to respond, I wish to have medical personnel apply all available technology and available medical procedures necessary to preserve my life.

_____While at the Emergency Care Facility, if I am still unable to respond, I DO NOT wish to have medical personnel apply all available technology and available medical procedures necessary to preserve my life.

_____I already have records of this decision, and I authorize you to obtain a copy:
Where: Person/Organization_____
Address:_____
Phone:_____

I am aware that I can change or revoke this directive at any time.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Limits of Confidentiality

The contents of counseling, intake, or assessment sessions are confidential. In order for any information be it verbal or written about a patient to be disclosed to a third party for any reason requires the written consent of the patient. or the patient's legal guardian. It is the policy of this organization not to release any information about a patient without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a patient discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the patient.

Abuse of Children and Vulnerable Adults

If a patient states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Patient's Death

In the event of a patient's death, the spouse or parents of a deceased patient have a right to access their child's or spouse's records.

Professional Misconduct

Other health care professionals must report professional misconduct by a health care professional. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of patients when a court order has been placed. Patient's who are on probation, court ordered to treatment or referred by the Department of Juvenile Justice, Department of Human Resources or the county Juvenile Court may have waived certain rights to confidentiality prior to referral to our services.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor patients have the right to access the patient's records.

People with Disabilities

Any release of information on people with disabilities will be governed by the rules as outlined in the American Disabilities Act of 1990 exceptions and the HIPPA Regulations and Guidelines. All information disclosed under the exceptions will be discussed with the Consumer and/or Guardian and proper releases will be requested. Any additional disclosed information will be regulated under the "Other Provisions" as discussed below.

HIPPA Guidelines

Each consumer and/or guardian will be supplied with a copy of the HIPPA Guidelines as designated by government rules and regulations pertaining to Patients Rights to Privacy.

Audio/Video Taping

In the event it becomes necessary to audio and/or video tape a patient for treatment or supervision purposes, a specific consent form for the purpose of audio and/or video will be required. No recordings on any kind will be conducted without the expressed consent of the patient.

Other Provisions

Advanced Counseling Services, does not conduct research on any of their patients. Outcome measure, as pertains to the effectiveness or non-effectiveness of our services, are collected and analyzed to ensure that the best quality treatment. No personal information on any patient will be disclosed, nor will any patient be identified by any of the outcome information collected.

Insurance companies and other third-party payers are given information they request regarding services to patients. Information such as type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

In the event information about patients is disclosed in consultations with other professionals in order to provide the best possible treatment, the name of the patient, or any identifying information, is protected. Only relevant clinical information about the case is disclosed.

When couples, groups, or families are receiving services, separate files are kept for each individual for information that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the patient, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

In the event in which we may need to reach you by phone, text, or email such as emergency closings due to bad weather, appointment cancellations or reminders, or to give/receive other information, efforts will be made to preserve confidentiality. Please let us know your preference when contacting you, and how you would like for us to identify ourselves.

Advanced Counseling Services

Please let us know your preference:

_____ CELL Phone number: _____
How should we identify ourselves? _____
May we say the clinic name? ☐ Yes ☐ No

_____ WORK Phone number: _____
How should we identify ourselves? _____
May we say the clinic name? ☐ Yes ☐ No

EMERGENCY Phone number: _____
How should we identify ourselves? _____
May we say the clinic name? ☐Yes ☐ No

I (We) agree to the above limits of confidentiality and understand their meanings and ramifications.

Patient's name (please print): _______Date: _____

Patient's (or guardian's) signature: _____Date: _____

Therapist Signature: _____Date: _____

Advanced Counseling Services

Accept Assignment

I authorize Advanced Counseling Services to keep my signature on file for the purpose of assignment of health care benefits.

I assign my insurance benefits to the provider listed above. I understand that this form is valid indefinitely unless I cancel the authorization through written notice to this clinic.

Patient's name: _____ Date: _____

Insurance Name: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name_____ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**_____

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered**	**Bothered a little**	**Bothered a lot**
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods	☐	☐	☐
e. Pain or problems during sexual intercourse	☐	☐	☐
f. Headaches	☐	☐	☐
g. Chest pain	☐	☐	☐
h. Dizziness	☐	☐	☐
i. Fainting spells	☐	☐	☐
j. Feeling your heart pound or race	☐	☐	☐
k. Shortness of breath	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.
Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).
Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

3. Questions about anxiety.		NO	YES
a.	In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	☐	☐
If you checked "NO", go to question #5.			
b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐

4. Think about your last bad anxiety attack.		NO	YES
a.	Were you short of breath?	☐	☐
b.	Did your heart race, pound, or skip?	☐	☐
c.	Did you have chest pain or pressure?	☐	☐
d.	Did you sweat?	☐	☐
e.	Did you feel as if you were choking?	☐	☐
f.	Did you have hot flashes or chills?	☐	☐
g.	Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	☐	☐
h.	Did you feel dizzy, unsteady, or faint?	☐	☐
i.	Did you have tingling or numbness in parts of your body?...	☐	☐
j.	Did you tremble or shake?	☐	☐
k.	Were you afraid you were dying?	☐	☐

5. Over the <u>last 4 weeks</u>, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days
a.	Feeling nervous, anxious, on edge, or worrying a lot about different things.	☐	☐	☐
If you checked "Not at all", go to question #6.				
b.	Feeling restless so that it is hard to sit still.	☐	☐	☐
c.	Getting tired very easily.	☐	☐	☐
d.	Muscle tension, aches, or soreness.	☐	☐	☐
e.	Trouble falling asleep or staying asleep.	☐	☐	☐
f.	Trouble concentrating on things, such as reading a book or watching TV.	☐	☐	☐
g.	Becoming easily annoyed or irritable.	☐	☐	☐

FOR OFFICE CODING: Pan Syn if all of #3a-d are 'YES' and four or more of #4a-k are 'YES'. Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

	NO	YES
6. Questions about eating.		
a. Do you often feel that you can't control what or how much you eat?	☐	☐
b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
If you checked "NO" to either #a or #b, go to question #9.		
c. Has this been as often, on average, as twice a week for the last 3 months?	☐	☐

7. In the last 3 months have you often done any of the following in order to avoid gaining weight?	**NO**	**YES**
a. Made yourself vomit?	☐	☐
b. Took more than twice the recommended dose of laxatives?	☐	☐
c. Fasted — not eaten anything at all for at least 24 hours?	☐	☐
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐

	NO	YES
8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	☐

	NO	YES
9. Do you ever drink alcohol (including beer or wine)?	☐	☐
If you checked "NO" go to question #11.		

10. Have any of the following happened to you more than once in the last 6 months?	**NO**	**YES**
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	☐	☐
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	☐	☐
c. You missed or were late for work, school, or other activities because you were drinking or hung over.	☐	☐
d. You had a problem getting along with other people while you were drinking.	☐	☐
e. You drove a car after having several drinks or after drinking too much.	☐	☐

11. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank.
Alc Abu if any of #10a-e is 'YES'.

Advanced Counseling Services

465 Winn Way, Suite 150 678-732-0435 office
Decatur, GA 30030 678-732-0349 fax

RELEASE OF INFORMATION

Patient's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

I, _____ , authorize **Advanced Counseling Services** to:

____ (send) or ___ (receive) the following information ____(to) or ___(from)

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.

- ____ Academic testing results
- ____ Behavior programs
- ____ Progress notes
- ____ Intelligence testing results
- ____ Medical records
- ____ Personality profiles
- ____ Psychological evaluation
- ____ Substance abuse
- ____ Service plans
- ____ Summary reports
- ____ Vocational testing results
- ____Entire record
- ____ *Psychotherapy Notes
- ____ Other, specify_____

The above information will be used for the following purposes:

- ____ Treatment Planning
- ____ Treatment Update
- ____ Collaboration of treatment
- ____ Case review
- ____ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the patient, please attach a copy of this authorization to receive this protected health information.

Patient's Signature: _____ Date: _____

Parent/guardian/personal representative (if applicable)

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF

Privacy Notice
Patient Rights
Financial Policy
Advanced Directives
Consent to Treatment

_____		_____	
Client Signature	Date	Parent/Guardian Signature	Date
_____		_____	
Printed Name	Date	Parent/Guardian Printed Name	Date
_____		_____	
Therapist Signature	Date	Witness Signature	Date