# Embrace Counseling and Consulting, LLC

*Where Grace, Love and Hope Greet You at the Door*

# New Client Intake Information

Today's Date: _____

INSTRUCTIONS FOR FILLING OUT FORMS

Please use a pen (not a pencil) to complete these forms. It will take about 30-45 minutes for you to complete.

The questions you will find on these forms are helpful in your treatment. The more I understand about your history and your personal situation, the more I will be able to help you. However, if you find some of them too uncomfortable, feel free not to answer them.

These forms take time and effort on your part. Completing them outside of your appointment time will enable you to talk about your more immediate concerns during your appointment. **Time used to complete forms during your schedule session cannot be recovered or rescheduled.**

**Identifying/Contact Information:**

Name: _____ Birthdate: _____ Age: _____ Sex: M F

Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Email Address: _____ OK to email confidential messages? ___Y ___N

Racial/Ethnic Background: _____

Telephone: (H)_____(C)_____(W) _____

OK to leave confidential messages? ____ Y ____ N

Presently living with: _____

Emergency Contact: _____Phone: _____

Your Name: _____ Date: _____

*Welcome to your 1st step in Mental Health and Wellness*

**Current Situation:**

Briefly describe the reason you are seeking counseling:

_____

_____

When has the problem improved? Who else was involved? _____

_____

When has the problem worsened? Who else was involved? _____

_____

Do you have any concerns about the way anger is handled in your relationships? _____

_____

Has your partner, if any, ever pushed, shoved, or hit you? _____

Is there anything else that you believe might be important for your counselor to know at this time? _____

_____

Education Years of education completed (K-12, College: 13-16+): ____ Degrees received:
_____ Specialized training or trade school: _____

Did you have any trouble learning in school? _____

Do you have any learning or developmental disabilities? Please specify: _____

Do you have any background/experiences in the military? ____ Describe briefly: _____

_____

Current spouse's (if any) years of education: _____ Degrees: _____

Current Employer: (if applicable) _____

Company Address:_____(W) Phone _____

Present Occupation:_____

Your Name: _____ Date: _____

**Spiritual History**:

Would you like Spirituality to be integrated into therapy? *Please initial* _____ Yes _____ No

Religious Affiliation (*if any*): _____

Do you currently attend a place of worship? _____Yes _____ No

List a Few Words to Describe Your Personal Faith: _____, _____, _____

Do you have any sleep problems? _____ Yes _____ No, If yes, please describe:_____

**General Information**:

How would you rate your overall physical health? □ Excellent □ Great □ Good □ Fair □ Poor

Do you have any Medical Conditions? ____ Yes ____ No; If yes, please describe below:

_____

List any medications you are taking, if any: _____, _____, _____

**Please list the names and relationships of the most important people in your life:**

1.

2.

3.

Do you have pets? □ Yes □ No If yes, please list: _____, _____

Did anyone in your family die before you were 18 years old? [] Yes [] No *if yes*, Who?

_____

How old were you? _____ Other family deaths? _____

**Abuse/Trauma History**:

Have you been abused or assaulted? _____YES_____ NO _____ DON'T REMEMBER
Did you witness abuse between your parents? ____YES _____ NO _____DON'T REMEMBER
Did you witness abuse between parent and child? _____YES _____NO _____ DON'T REMEMBER

Your Name: _____ Date: _____

**More about You:**

I am usually: (*please circle all that apply*) CONFIDENT , HARD WORKER, ORGANIZED , SYMPATHETIC , GOOD LISTENER , DEPENDABLE, SENSITIVE, LOGICAL, LOYAL, GRACIOUS, DECISIVE, RESPONSIBLE , PATIENT UNDERSTANDING, SENSE OF HUMOR, EASILY ANGERED, FRUSTRATED, OVERWHLEMED, SAD, DISCOURAGED, OTHER : _____, _____, _____, _____

Are you usually: □ Early □ On Time □ Running Late

Do you exercise regularly? □ Yes □ No

If yes, please describe what you do and how often: _____

_____

How often do you watch television?

What is your favorite TV Show? _____

What are your favorite Hobbies? _____ , _____

What is your favorite Sport? _____Team?_____

What do you do for fun? _____, _____

What is your idea of a perfect vacation? _____

_____

What is your primary Goal (s) for Therapy:

1._____

2._____

How did you hear about me?

_____ Referral (Client) _____ Referral (Clinician) _____ Google _____ Church

_____ Psychology Today _____ Transfer Client _____ Walk-In _____ Court-Ordered

Your Name: _____ Date: _____

**Coping/ Emotion Management**:

Has addiction been a problem in your life or others that have impacted you? _____ Yes _____ No

How often if any do you use the following?

Marijuana: _____ Not at all _____ Daily _____ Weekly _____ Social Only

Alcohol : _____Not at all _____ Daily _____ Weekly _____Social Only

Opiates: _____ Not at all _____ Daily _____ Weekly _____ Social Only

Other: _____ Not at all _____ Daily _____ Weekly _____ Social Only

***Please attach a copy of your driver's license [and your spouse's if requesting couple's therapy) when you are submitting this Intake Form. This information will be kept confidential and will only be used to confirm your identity if you are scheduled for video-based counseling session.***

Printed Name: _____ Date: _____

Signature: _____

Printed Name: _____ Date: _____

Signature: _____

## Finding Your ACE Score

**While you were growing up, during your first 18 years of life:**

1. Did a parent or other adult in the household **often or very often**...
   Swear at you, insult you, put you down, or humiliate you?
   **or**
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**...
   Push, grab, slap, or throw something at you?
   **or**
   **Ever** hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**...
   Touch or fondle you or have you touch their body in a sexual way?
   **or**
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that ...
   No one in your family loved you or thought you were important or special?
   **or**
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   **or**
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   **Often or very often** pushed, grabbed, slapped, or had something thrown at her?
   **or**
   **Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard?
   **or**
   **Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

**Now add up your "Yes" answers: _____ This is your ACE Score.**

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## Consent to Treatment

**(Please initial each section!!!)**

_____ I acknowledge that I have received, have read (or have had read to me), and understand the "Counseling Information and Agreement" document. I understand that I am free to discuss any aspect of my treatment with my therapist at any time. I consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand the benefits and risks of therapy and that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I understand the provisions and limits of confidentiality established by Federal (HIPAA) and Georgia laws. I understand that my therapist operates under the professional and ethical standards of the American Counseling Association (ACA), the American Association for Marriage and Family Therapy (AAMFT), and/or the National Association of Social Workers (NASW), as appropriate to my therapist's specialization, and to the Ethics Standards of the Christian Association for Psychological Studies (CAPS). I am aware that I may stop my treatment with this therapist at any time. My only remaining responsibility will be to pay for the services I have already received. I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, my account will be charged the full session fee for that appointment, and any credit card on file for my account will be used to collect payment. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, my therapist may stop my treatment. My signature below shows that I understand and agree with all of these statements.

_____ Your therapist will discuss the amount of your fee .You are responsible for paying at the time of your session unless prior arrangements have been made. Payment will be collected at the beginning of your session using your credit card on file or cash. We are unable to accept checks or insurance at this time. If you refuse to pay your debt, your therapist reserve the right to use an attorney or collection agency to secure payment.

_____ In addition to weekly appointments, it is our practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me.

_____ I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Lidums, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record. If I believe it necessary to subpoena my therapist, I would be responsible for his or her expert witness fees in the amount of $850.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time spent over one half (1/2) day would be billed at the rate of $150.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

_____ I am required to keep appropriate records of the counseling services that I provide. Your records are maintained within a secure Electronic Medical Record (EMR) or Paper Chart. These records will include your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself or others, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have our decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

_____ Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

_____ I am often not immediately available by telephone. I do not answer the phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, however, it may take 24 – 48 hours for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact the **Georgia Crisis and Access line at 1-800-715-4225**, 2) go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering your care if applicable.

_____ Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____ _____

Signature of client (or parent/guarding acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist undersigned below, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent to treatment.

_____ _____

Signature of Therapist Date

_____

Printed name

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Notice of Privacy Practices Confirmation The Health Insurance Portability and Accountability Act (HIPAA) has created patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("security rules"). HIPAA applies to all health care providers, including mental health care. Providers and health care agencies throughout the country are now required to provide patients with notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

Please read our Notice of Privacy Practices, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, we make every effort to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification. Please read the following paragraph and sign your agreement below. By Law, Embrace Counseling and Consulting is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights Document.

**HIPPA Compliance Officer: Lyresa McGriff, LPC**

I have read and understand Embrace Counseling and Consulting, LLC Notice of Privacy Practices, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and that I may, at any time, now or later, ask any questions about or seek clarification of the matters discussed in this document.

_____

Printed name of client

_____

Printed name of parent/guardian, if applicable

_____ _____

Signature of client (Or parent/guardian for clients under age 18) Date

848 Hiram Acworth Highway Bldg 100 Terrace Level Hiram Georgia 30141
2480 Windy Hill Road, Ste 105 Marietta Georgia 30067
(678) 664-4311

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## Financial Responsibilities Form

***Your Name:*** _____ ***Date:*** _____

For the financial health of the practice, it is our policy to collect all amounts owed on the day services are rendered prior to your session. Please provide complete payment information for billing which will occur on the day of each session. DEBIT/CREDIT CARDS and CASH are accepted. ***Checks will not be accepted.***

Full Name as seen on Card: _____

Client's Name if different from Cardholder: _____

Type of Card: (*please circle*) VISA ~ MASTERCARD ~ AMEX ~ DISCOVER ~ HSA Card

Card Number: _____

Expiration Date: _____ CSV: _____ Billing Zip Code: _____

_____ ☐ I confirm that the information provided above is true and accurate (***Please initial***)

_____ ☐ My signature below gives authorization to bill my credit card for services on the day of each session. (***Please initial***)

_____ ☐ I understand that my card will be billed if I fail to cancel within 24 hours of my scheduled appointment or no-show the appointment at a full session fee. (***Please initial***)

***If payment is taken over the phone due to card information update or payment being made on behalf of a client that is not the cardholder, I authorize information obtained to be used to make payment for therapy sessions with my consented therapist.***

**Signature of Card Holder:** _____ Today's Date _____

*Your completed form will be placed on file for authorization records. Your receipt and/or bank statement will show Embrace, Embrace Square, or IPID or IPID Square as billing services (**not the name of your therapist**)*

# Notice of 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

Your counselor 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 I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another counselor.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I 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 this 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 this clinic such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of this clinic such as releasing, transferring, or providing access to information about you to other parties.

## II. Uses and Disclosures Requiring Authorization

Your counselor may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the counselor is asked for information for purposes outside of treatment, payment or health care operations, he/she will obtain an authorization from you before releasing this information. He/she will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes your counselor has made about your conversations during a private, group, joint, or family counseling session, which have been 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) the counselor or his/her representatives has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

## III. Uses and Disclosures with Neither Consent nor Authorization

Your counselor may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If your counselor has reasonable cause to believe that a child has been abused, he/she must report that belief to the appropriate authority.

- *Adult and Domestic Abuse* – If your counselor has reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, he/she must report that belief to the appropriate authority.

- *Health Oversight Activities* – If your therapist is the subject of an inquiry by the Georgia State Board of Examiners of Psychologists, protected health information regarding you may be disclosed in proceedings before the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the counseling services provided to you by an intern or the records thereof, such information is not privileged under state law, and may be released subject to a court order. An effort will be made to inform you 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* – Your counselor may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

## IV. Patient's Rights and Counselor'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. However, your counselor not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a counselor. On your request, the counseling center 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 in the mental health and billing records used by your counselor to make decisions about you for as long as the PHI is maintained in the record. Your access to PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, your counselor or a designated agent of the counseling center 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. Your counselor or a designated agent may deny your request. On your request, your counselor or a designated agent 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. On your request, your counselor or a designated agent 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 upon request, even if you have agreed to receive the notice electronically.

Duties:

- The counseling center is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.

- The administration of the counseling center reserves the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, it is required that the center abides by the terms currently in effect.

- If these policies and procedures are revised, you will be notified by mail at your last known address.

## V. Complaints:

If you are concerned that your counselor or this counseling office has violated your privacy rights, or you disagree with a decision made about access to your records, you may contact:

**Director: Lyresa McGriff, LPC @ (678) 664-4311**

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

Embrace Counseling and Consulting reserves the right to change the terms of this notice and make new notice provisions effective for all PHI that it maintains. You will be provided with a revised notice by electronic delivery and/or by your therapist. An updated copy is available for review in the waiting room of Embrace Counseling and Consulting, LLC.