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.____

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

Your Name: ___________________________ Date: _______________

How did you hear about Embrace Counseling? *Please check which one applies.*

______ Referral (Client) ________ Referral (Clinician) _________ Google _________ Church

______ Psychology Today _________ Transfer Client __________ Walk-In __________ Court-Ordered

_______ Insurance __________ EAP

***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: ____

Your Name: ____________________________ Date: _______________

Embrace Counseling and Consulting, LLC

Where Grace, Love and Hope Greet You at the Door

Consent to Treatment

(Please initial each section!!!)

_______ I acknowledge that I have received and 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. **<u>I know that I must call to cancel an appointment at least 24 hours before the time of the appointment</u>**. 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. If you are a self-pay Client (Not using insurance), you will receive a good faith estimate from your therapist via in writing or email correspondence. 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 reserves the right to use an attorney or collection agency to secure payment. If you are utilizing your insurance, you will be responsible for any client balances not paid by insurance based on the contracted rate of reimbursement. (ie…copayments, deductibles and co-insurances) EAP services are billed however, if information received fails to deliver payment for insurance due to incorrect information from client, client is aware that payment for services will be charged to card on file and reimbursed once payment is received for services rendered.

_______ 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.

Your Name: ______________________________ Date: ________________

_______ 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 $950.00 for one-half (1/2) day to be paid five (7) 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.

________ (**Clinical Intern Acknowledgment**) I acknowledge that I have received notification that I am receiving therapy services from a Master's Clinical Intern who is under the Direction and Supervision of Embrace Counseling and Consulting, LLC/Lyresa McGriff, LPC

________ (**Clinical Intern Acknowledgement**) I understand that I may be asked to have a session recorded (Audio or clinician facing Only) to assist in providing clinical training of assigned intern for treatment services. These recordings would only be for assessing the intern and their continued education to meet graduation and licensure requirements. Recordings will be disposed of at the end of each semester and/or quarter term.

Your Name: ____________________________ Date: _______________

______ 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 or (*Intern if applicable*) Date

____

Printed Name

Your Name: ____________________________ Date: _______________

Embrace Counseling and Consulting, LLC

Where Grace, Love and Hope Greet You at the Door

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

Your Name: ______________________________ Date: ________________

Embrace Counseling and Consulting, LLC

Where Grace, Love and Hope Greet You at the Door

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

Number:____ Expiration Date: ______________________

CSV: ________________ Billing Zip Code: ____________________

(**Please initial**) ________ ? 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**) ________ ? I understand that my card will be billed for any balances due for self-pay or from insurance balances deemed client responsibility based on contracted rate.

(**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**)

Embrace Counseling and Consulting, LLC

Where Grace, Love and Hope Greet You at the Door

Privacy Practices for your Review and Records

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. The terms of this Notice of Privacy Practices ("Notice") apply to [**Embrace Counseling and Consulting, LLC**], its affiliates and its employees/Contractors. [**Embrace Counseling and Consulting, LLC**] will only share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by [Practice Name]. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment, or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests,

Your Name: ____________________________ Date: _______________

medical history, etc. Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company

Privacy Practices for your Review and Records cont'd…

to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

This is a document intended solely for general informational purposes. It does not constitute legal advice. The reader should consult with knowledgeable legal counsel to determine how applicable laws apply to the reader's specific circumstances. Since it is possible that the laws or other circumstances may have changed since publication of this form, the reader should consult with knowledgeable legal counsel to discuss any action he or she may be considering as a result of reading this form.

Uses and Disclosures for Health Care Operations:

We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care. Individuals Involved in Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts for that entity to locate a family member or other persons that may be involved in some aspect of caring for you. Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information. Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below. Research: In

Your Name: ____________________________ Date: ________________

limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional

Privacy Practices for your Review and Records cont'd…

Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information. Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such request in writing to the Privacy Officer at the address below.

Other Uses and Disclosures:

We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

• Any purpose required by law

• If we suspect child abuse or neglect to children/minors, elderly and disabled individuals protected by

ADA/ the law

• To your employer when we have provided health care to you at the request of your employer (eg. EAP)

• Court or administrative ordered subpoena or discovery request

• To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law

DISCLOSURES REQUIRING AUTHORIZATION:

Psychotherapy Notes:

We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following:

(1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you)

(2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law

Your Name: ____________________________ Date: ________________

(3) as required by law

Privacy Practices for your Review and Records cont'd…

(4) for health oversight activities authorized by law

(5) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.

You do, however, have the right to restrict disclosure of our protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid [Embrace Counseling and Consulting, LLC] in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records. Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints:

If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer.

Lyresa McGriff, LPC

(678) 664-4311

Your Name: ____________________________ Date: _______________