Eagles Landing Christian Counseling Center, Inc. * Main Campus 1944 Brannan Rd. * McDonough, Georgia * 30253 * 678-289-6981

Adult Intake Information

Date: _____

Welcome to Eagle's Landing Christian Counseling Center! We know that you have many options for behavioral health care, and we appreciate your choosing our team to assist you. On the following pages, please take time to tell us about you. Please complete this before your first session and your counselor will then review this information together with you in your first and subsequent sessions.

Client Information (Please Print)

Name:_____ Birth Date:_____/_____/_____

Gender: M F Age:_____ Telephone: Mobile: _____

Ethnicity:_____Work:_____Home:_____

Address (No. & Street/P.O. Box):_____Apt. _____

City: _____ State: _____ Zip: _____

I would like to receive notification reminders of my appointment 48 hours in advance so that I may comply with Eagles Landing's policy for missed appointments and avoid a $65 missed appointment fee. Check all that apply and provide current contact information and circle your preference:

⎦ Electronic Voice_____ Text _____

⎦ Email _____

Employment Status: Full-time Part-time Unemployed Retired

Occupation:_____ Employer:_____

Years of Education: High School Trade School College Graduate School

Degree(s) Earned:_____Current Student: Y N Full-time Part-time Yr. _____

School (If presently enrolled): _____

Military Service: Y N Branch:_____MOS:_____Discharge Date: _____

In case of emergency, please contact: Name: _____

Relationship:_____ Telephone: _____

Referred by: _____

Are you currently seeing another counselor or psychiatrist? Y N
If yes, Name:_____Phone: _____

Have you been in counseling before? Y N If yes, when? _____
With whom?_____Was it helpful to you? _____

Health Information

Rate your current physical health: Excellent Good Average Declining Poor

Height: _____ Weight: _____ Recent Weight Changes: (lbs) lost:_____gained:_____

Do you have any illnesses, injuries, or disabilities (past or present – including problems at birth) that we should know about:

_____

_____

Name of Primary Care Physician/Clinic:_____
Address:_____Telephone:_____

If you enter treatment with me, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes_____ No _____

Please list ALL medications (prescription or over-the-counter) that you are currently taking (If necessary, use additional page to list ALL current medications.):

_____

_____

_____

What kinds of physical exercise do you get? How often? _____
How much caffeine do you consume each day? _____
Do you try to restrict your eating in any way? How? Why? _____

Substance Use

Have you used any tobacco products in the last 12 months? Yes No

How many standard drinks containing alcohol do you have on a typical day? (1 standard drink is .6 oz of alcohol)

1 or 2 3 or 4 5 or 6 7 to 9 10 or more

Women: How many times in the past 12 months have you had 3 or more drinks in one setting?
__25 or more times____13-24 time_____6-12 times___1-5 times none

Men: How many times in the past 12 months have you had 5 or more drinks in one setting?
__25 or more times____13-24 time_____6-12 times___1-5 times none

Do you participate in any risky behaviors? Yes No If so, what kind? _____

Marital Status: Single Engaged Married Separated Divorced Widowed
Name of Spouse:_____Age:_____How long married? _____

Children:

Name	Age	Gender	Grade	Health
1.				
2.				
3.				
4.				

Spiritual Information:

I consider myself: Christian Jewish Buddhist Muslim Hindu Agnostic Atheist Other Unknown
I am happy with my current spiritual journey: Yes No Why? _____
I am active in the practice of my faith: Yes No Why? _____
I am visiting a Christian Counseling Center because: (Circle the number of all that apply)
1) I hope to get counseling from a Christian perspective;
2) I am open to hearing a Christian perspective on my issues;
3) I was referred here by a friend who was helped and hope to have the same good result;
4) This is a Christian counseling center? What does that mean?

How much do you want spirituality included in your treatment?
None Some Neutral A lot All about spirituality

For Women Only: (men skip to "Checklist of Concerns")

At what age did you start to menstruate (get your period)? _____
How regular are your periods?_____How long do they last?_____Heavy_Light _____
How much pain do you have?_____Other experiences during period: _____
PMS experiences: _____

If your menopause has started, at what age did it start?_____What menopausal signs or symptoms have you experienced? _____
Have you had a hysterectomy? Y N At what age?____Are you taking Hormone Replacement Therapy? Y N Type: _____

Please list all of your pregnancies and what happened with these pregnancies (your age, type of birth, miscarriage, abortion, any problems):_____

_____

_____

_____

Checklist of Concerns:

Circle any LOSSES that you have experienced:

Death of: spouse child father mother sister brother grandmother grandfather friend;

Divorce	Abortion	Career/Job loss
Separation	Infertility	Other:_____
Broken engagement	Bankruptcy	_____
Miscarriage	Homelessness	

Circle any of these EXPERIENCES you have had in your life:

Child abuse: Physical, Emotional, Sexual, Incest From: Father, Mother, Sibling, Stepfather, Stepmother, Step Sibling, Uncle;

Spouse abuse: Physical, Emotional, Sexual, From which relationship? Spouse's drug or alcohol problems; Spouse's mental illness; _____;

From Parents: divorce; drug or alcohol problems; mental illness; Foster care; Abandonment; Rape; ; Assault; Suicide attempt;

Other: Auto or industrial accident; Major illness; Robbery Major surgery; Other:_____

Circle any PROBLEMS that concern you now:

Relationships	Dependency	Temper
Alcohol	Communication	Self-control
Drugs	Career	Loss of Appetite
Binge eating	Sex	Memory
Diet or exercise	Self-esteem	Parenting
Work too much	Health problems	Finances
Shopping	Sexual thoughts	Nightmares
My Anger	Anxiety	Concentration
Loneliness	Stress	My thoughts
Suicidal-thoughts	Energy	Feelings
Procrastination	Legal matters	God
Depression	Sleep problems	Other: _____
Grief	Relaxation	
Mood swings	Fear	

Reason for Today's visit:

In your own words, briefly describe the main problem which prompted you to seek counseling at this time:

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Informed Consent for Financial Policy and Contract for Professional Services

Thank you for choosing **Eagle's Landing Christian Counseling Center** as your Biblically rooted, professional mental health provider. We are committed to the success of your treatment. We are a non-profit organization. While keeping fees as low as possible, our counselors still need to be reimbursed for their services. Lower cost consultation is available from time to time with our interns. Below you will find the details of our financial policy. A signed agreement to this policy is required before beginning treatment.

1-A. GENERAL FINANCIAL POLICIES FOR ALL CLIENTS:

- Payments are due at the time of service. Please pay the receptionist or service provider before your meeting. We accept payment by cash, check, debit, Visa, Discover, and MasterCard.
- A **$35.00 fee is charged for any checks returned from the bank for any reason and is due in cash at your next session.**
- If you are using an insurance company that we accept, we will bill your insurance company for you. Clients are responsible for all payments, including co-pays, at the front desk, before seeing their counselor. In order to maintain standing appointments, your account must remain current.
- All checks should be made payable to: Eagle's Landing Christian Counseling Center, or ELCC.
- Sessions are 45 – 60 minutes long. A session lasting 1 ½ hours long is considered 2 sessions.
- Phone conversations that exceed 20 minutes in length may be charged a one-session fee and will not be covered by insurance.
- We do not keep cash in the office and we are unable to make change of more than$20 for $100 bills.

1-B. MISSED OR CANCELLED APPOINTMENTS:

- Please help us better serve you by keeping scheduled appointments. If you are not going to keep your appointment, please allow time for the therapist to offer the appointment to someone else.
- **You will be billed for missed appointments and appointments that are not cancelled 48 hours in advance. Insurance companies will not reimburse for missed appointments. You will be expected to pay a $65 missed appointment fee.**
- Failure to pay may impact your credit and you may be required to keep a credit card on file to bill for copayments and missed appointments.
- Exceptions will be made in the event of an accident or an emergency [i.e.., breaking down, sudden illness, or sudden illness of a minor child, etc. Please note that "having to work" is not considered an emergency.]
- If you, or a family member, pay for a session in advance that you subsequently do not use, you will not receive a refund. However, you may apply it to future sessions.

1-C. LATE ARRIVALS OF CLIENTS AND/OR THERAPIST RUNNING LATE:

- We understand that sometimes things happen and you may arrive late for your appointment. We will do our best to give you your full 45-60 minutes session as long as it doesn't cut into the next client's time. Please understand that we try to stay on schedule as much as possible. By the same token, we are counselors dealing with people and their feelings and occasionally we have urgent situations. Therefore, sometimes we may run late. It is the counselor's prerogative to reschedule you or to continue to run behind by taking some of the next scheduled session to give you your 45-60 minutes. If you choose to leave before 30 minutes of your session time has passed, you are still expected to pay for the session. Please understand that we do our best to treat people as people, not appointments. Please respect our counselors by understanding that they are people too.

1-D. MINORS RECEIVING TREATMENT:

- The parent/guardian(s) is responsible for payment at the time of service. We will not bill parents or others for a minor's session.
- No minor can be treated without signed consent of a parent or guardian.
- Unaccompanied minors will be denied services (except in the case of an emergency). Parent/guardian must be in the office while minor is being treated. Children 16 or 17 may be an exception with notice to the counselor in advance.
- Parents are expected to be involved with treatment of a minor. If a parent or guardian is unwilling or unable to participate, parent must consult with therapist before minor begins treatment. (Note: Additional fees may apply)
-

Disclosures: Please Read Each Item Listed Below And Initial Each Indicating Agreement:

- —— I agree to conduct myself in an appropriate manner. Small children must be attended at all times.
- —— **Confidentiality**: I understand that no information about me or my issues will be disclosed to anyone outside of the Counseling center. However, for the purposes of supervision, billing, and training, *some* information may be shared with other staff. I will maintain the confidentiality of anyone I see in the counseling office or in my group.

- **Limits of confidentiality**: I understand that physical abuse, sexual abuse, neglect, of children (under 18 years of age) or endangerment through the witnessing of domestic violence must be reported by law. I understand that physical abuse, sexual abuse, or neglect of the elderly (65 years and older) or disabled must be reported by law. I understand that intent to do harm to another person will be reported to that person and the police. ELCCC does not guarantee that other counseling clients or family members will maintain confidentially.
- **HIV/AIDS CONFIDENTIALITY STATEMENT**

ELCCC does NOT perform HIV/AIDS testing. ELCCC does everything within its reasonable power to follow the Georgia Laws regarding the disclosure or non-disclosure of HIV/AIDS. This includes:

If a client discloses their HIV/AIDS status to ELCCC personnel, ELCCC personnel or contractors will not, pursuant to Georgia legal code, knowingly or intentionally disclose that information to another person or legal entity, nor can they be compelled by subpoena, court order, or other judicial process to disclose that information.

However, HIV/AIDS confidential information may be disclosed to the person identified by that information or, if that person is a minor or incompetent person, to that person´s parent or legal guardian.

In addition, HIV/AIDS confidential information may be disclosed to any person or legal entity designated to receive that information when that designation is made in writing by the person identified by that information or, if that person is a minor or incompetent person, by that person´s parent or legal guardian.

HIV/AIDS confidential information may be disclosed to any agency or department of the federal government, this state, or any political subdivision of this state if that information is authorized or required by law to be reported to that agency or department.

In addition, if any ELCCC employee, contractor, or staff member reasonably believes that another employee, contractor, or staff member, the spouse or sexual partner or any child of the client, spouse, or sexual partner is a person at risk of being infected with HIV by that client, the employee, contractor, or staff member may disclose to that employee, contractor, or staff member, spouse, sexual partner, or child that the client has been determined to be infected with HIV, after first attempting to notify the client that such disclosure is going to be made.

Limits of the Therapy Relationship and Social Media

Psychotherapy is a professional service and it must be limited to the relationship of therapist and client only. If we were to interact in any other ways, we would then have a "dual relationship," which would not be right and may not be legal. The different therapy professions have rules against such relationships to protect us both.

Counseling Relationships

Dual relationships like these are improper:

- I cannot be your supervisor, teacher, or evaluator. I cannot be a therapist to my own relatives, friends (or the relatives of friends), people I know socially, or business contacts. I cannot provide therapy to people I used to know socially, or to former business contacts. I cannot have any other kind of business relationship with you besides the therapy itself. For example, I cannot employ you, lend to or borrow from you or trade or barter your services (things like tutoring, repairs, child care, etc.) or goods for therapy. I cannot give legal, medical, financial, or any other type of professional advice. I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

Phone

Phone conversations are limited to 10-15 minutes and will be primarily for scheduling changes and notifications only, unless we agree upon TeleMental Health Counseling. You can contact me by leaving a voicemail message on my confidential voicemail and I will return the call within 12 hours. TeleMental Health counseling is available.

Location-Based Services

Please be aware if you use location-based services on your mobile phone you may compromise your privacy while attending session at my office. My office is not a check-in location on various sites such as Foursquare, however it can be found as a Google location. Enabled GPS tracking makes it possible for others to surmise you are a counseling client due to regular check-ins at my office location.

Courtesy Reminders

You can receive a courtesy telephone call, text, or email reminder. This is just a courtesy and whether or not you receive it, you are responsible for attending or canceling your session in a timely manner.

I would like to receive notification reminders of my appointment 48 hours in advance so that I may comply with Eagles Landing's policy for missed appointments and avoid a $65 missed appointment fee. Check all that apply and provide current contact information and circle your preference:

I prefer: Electronic Voice Text Telephone Number: _____

Email _____

Friending & Following

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends on these sites can compromise your confidentiality and our therapeutic relationship. I will not follow any client on Twitter, Instagram, blogs, or other apps/websites. If there is content you wish to share from your online life, please bring it into our sessions where we can explore it together.

Search Engines

It is not a regular part of my practice to search for clients on Google, Facebook, or other searchable sites. An exception could be during a crisis. If I have reason to suspect you are a danger to yourself or others and I have exhausted all other reasonable means to contact you and/or your emergency contact, then I may use a search engine for information to ensure your welfare. If this ever occurs, I will fully document the search and discuss it with you at your next session

Counselor's Quiet Hours & Vacation (to be completed by your individual counselor in session)

Counselors are not available between 9pm and 9am or on weekends.

During these hours, please refer to the Crisis Needs section. If you need to cancel your appointment, please call my cell phone during my work hours and leave a message. Remember that I prefer cancellations 48 hours in advance, and need to be more than 48 hours before your scheduled appointment or you will be charged the full fee.

Crisis Needs

In the event that you are having urgent suicidal thoughts, or need hospitalization, please go to the nearest emergency room or dial 911. You may also call the Georgia Crisis and Access Line, which can be reached at **800.715.4225** and **404.527.6700**. For urgent needs you may contact me at my after-hours number on my business card or by calling the office at **678-289-6981**. I will return you phone call as soon as I possibly can, but am frequently in session throughout the day. I will provide you with another counselor's name whom you may contact while I am away on vacation.

Counseling Contract:

I acknowledge that I have received, have read (or have had read to me), and understand the "Informed Consent" and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and 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 that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

My signature below shows that I understand and agree with all of these statements.

Signature of Patient_____ Date _____

I, the therapist, have discussed the issues above with the patient. 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.

Signature of therapist_____ Date _____

Copy accepted by patient Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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HIPPA: Consent for Purposes of Treatment, Payment and Healthcare Operations

Patient Name:_____DOB: _____

I hereby consent to the use or disclosure of my protected health information by the practice of Eagle's Landing Christian Center, hereinafter referred to as "ELCCC" for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by ELCCC may be conditioned upon my consent as evidenced by my signature on this document. I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to these restrictions, which I may request. However, if the practice agrees to the restrictions that I request, the restriction is binding to the practice and ELCCC.

I understand that I do not have to use my health insurance, but that by doing so I will be given a mental health diagnosis and this diagnosis will be revealed to the insurance company. In addition, they will have access to my complete medical record. If I chose not to use my health insurance, they will not have access to my medical record nor will they receive any information on my diagnosis for any reason.

The ONLY disclosures ELCCC makes are to 1) Client; 2) Minor client's guardian of record; 3) Insurance biller (Barb Ifill); 4) Accountant (Rhonda Burchett); 5) Supervisor for purposes of training and supervision only; 6) Insurance company IF you are using insurance; 7) Company/Church providing scholarship for sessions IF you are using scholarship for billing purposes only; 8) To officials by law if abuse or neglect are determined or suspected; 9) To those people you request IN WRITING to have your information released to, i.e., probation officer, attorney, etc. NO OTHER disclosures are intended or planned or made.

My "protected health information" means health information, including my demographic information, collected from me and created or received by ELCCC, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the practice's Notice of Privacy Practices, which has been provided to me by the practice, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health
information that will occur in my treatment, payment of my bills or in the practice's duties with respect to my protected health information. The Notice of Privacy Practices for the practice is also provided at 1944 Brannan Rd. McDonough, GA 30233. As provided in our notice, the terms of our notice may change. If changes are made, I may obtain a revised Notice of Privacy Practices by calling your office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

I have the right to revoke this consent, at any time, in writing, except to the extent that ELCCC or the practice has taken action in reliance on this consent.

_____ _____ Printed Name of Patient Date

_____

Signature of Patient or Personal Representative:

_____ _____

Description of Personal Representative's Authority Date

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RELEASE FROM LEGAL INVOLVEMENT

At times, individuals who come into counseling, whether it's individual counseling or family counseling, are having problems within their relationships. Unfortunately, some of these individuals may choose to end their marriage or relationship through the court system.

In order for each individual to have the freedom necessary to work on issues related to the problems at hand, things that are said during the counseling process are off limits to possible impending court proceedings. To this end, it is mandatory that as your therapist, I am released by all parties concerned in the counseling process from any legal involvement concerning the relationship or information learned about the relationship through the counseling process. This includes, but is not limited to, testifying in court for either party, being deposed by counsel for either party, filing any type of affidavit for either party, speaking with attorneys either in person or on the telephone for either party.

Due to the nature of confidentiality laws in the state of Georgia, it is my policy to prohibit the release of mental health records to current or former patients or parents of current or former patients. This includes release of the record for personal or legal use. The record can be released to another mental health care professional for the purpose of continuity of care.

I understand and agree that I may not have open access to my mental health record or to the mental health record of my partner, spouse, or child.

I further understand and agree that even though a record is usually opened in the name of only one of the members of the couple or family, all members that participate in the therapy process are seen as a unit and that confidentiality is extended to each participant in a few limited circumstances. In addition, if I am requested to testify, it does not mean that my testimony will be solely in your favor. I can only testify to the facts of the case and, when asked, to my professional opinion.

If you subpoena me to testify, by rates are as follows:

Preparation time (including submission of records): $150/hr
Phone calls: $150/hr
Depositions: $150/hr
Time required in giving testimony: $150/hr
Mileage: $0.40/mile
Time away from office due to depositions or testimony: $150/hr
All attorney fees and costs incurred by the therapist as a result of the legal action.
Filing a document with the court: $100
The minimum charge for a court appearance: $1500
A retainer of $1500 is due in advance at the time of the request. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $250 "express" charge. Also, if the case is reset with less than 72 business hours notice, then the client will be charged $500 (in addition to the retainer of $1500).

Patient's Name	Patient's Signature	Date
Partner's Name	Partner's Signature	Date
Parent's Name	Parent's Signature	Date
Parent's Name	Parent's Signature	Date
Witness' Name	Witness' Signature	Date

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Insurance Certification and Approval Form

(Complete if you are using insurance other than Medicaid)

Patient Name: _____, ____, _____ Date of Birth: ___/___/____
Last MI First

Street Address: _____City: _____

State: _____ Zip: _____Telephone: _____

Name of insured: _____, ____, _____ Date of Birth: _____/_____/_____
Last MI First

Relationship to patient: self wife husband parent child

Street Address: _____City: _____ State: _____ Zip: _____

Name of PRIMARY Insurance Company: _____ Do you have a second insurance? _____
ID on PRIMARY card: _____ Group ID: _____
Billing address for insurance company: Street Address: _____
City: _____ State: _____ Zip: _____
Telephone number on back of card for customer service or billing: _____

Name of SECONDARY Insurance Company: _____ NONE
ID SECONDARY on card: _____ Group ID: _____
Billing address for insurance company: Street Address: _____
City: _____ State: _____ Zip: _____
Telephone number on back of card for customer service or billing: _____

Request/Informed Consent to bill Insurance or Third Party Payers

By signing below, I request that Eagle's Landing Christian Counseling Center, Inc. to submit a claim to my health insurance for mental health counseling sessions.

I also understand that, in order to submit this claim to my insurance company that I will be given a provisional mental health diagnosis which may be along the lines of depression or anxiety disorder, according to the current symptoms I am experiencing.

In addition, I understand that the impact of this diagnosis appearing on my personal health record could, among other things, endanger my ability to purchase Life and/or Health Insurance in the future. I understand there could be other negative outcomes not mentioned in this Informed Consent and not foreseen by either my Individual counselor or ELCCC, Inc.

I agree to not hold ELCCC Inc. or my individual counselor responsible for <u>any</u> future ramifications of having been given a diagnosis for the purpose of mental health treatment.

In addition, I understand I am responsible to pay all co-pays and deductibles as required by my insurance company at the time of service. I understand that my co-pays cannot be waived for any reason.

Name: _____ Signature: _____ Date: _____

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Waiver of Medicare, Medicaid or other insurance Benefits/Agreement for Fee for Service

Please read and choose the paragraph that applies to you.

⎦ I am signing this form due to my decision to participate in outpatient psychotherapy. I understand that my provider is NOT a Medicare or Medicaid provider and therefore cannot bill Medicare or Medicaid for services I am requesting. I also understand I am free to seek such services from a Medicare or Medicaid provider now and in the future, but am choosing not to do so at this time.

⎦ I am signing this form due to my decision to participate in outpatient psychotherapy. I understand that my provider is NOT enrolled as a provider for my insurance company and that ELCCC will not be billing my insurance on my behalf. I may receive a receipt that I can submit to my insurance company for possible reimbursement, but ELCCC does not guarantee or promise any such reimbursement. I also understand I am free to seek such services from an enrolled provider now and in the future, but am choosing not to do so at this time.

⎦ I am signing this form due to my decision to participate in outpatient psychotherapy. I understand that my provider IS enrolled as a provider for my insurance company but I am choosing NOT to use my insurance at this time and will pay the fee for service. I understand that this means the office will NOT be billing my insurance for the cost of my sessions and I will be fully responsible for any and all fees. I understand that I am free to change my mind but must sign a different insurance contract if I do. I must give my counselor and the office a 7-day notice, provide my insurance information, and pay the appropriate co-pay upon arrival. I understand that the office cannot go back and bill past sessions to the insurance company but I am free to submit my receipts to the insurance company for reimbursement along with a copy of this letter showing my choice to opt-out of insurance initially.

By signing this form, I hereby agree that I am aware I will be personally financially responsible for the therapy. I also understand and agree that I am entering a fee-for-service and am accountable for payment of psycho-therapeutic services at the time they are received. I agree that I will notify my provider immediately should I enroll in another insurance plan as this would possibly invalidate this voluntary agreement.

Name:_____ Date of Birth: _____

Patient/Client Signature:_____ Date: _____