A Healing Journey Counseling & Consultation
650 Henderson Drive, Suite 202, Cartersville, GA 30120
Phone 770-334-2493 ■ Fax 770-334-2675
http://www.ahjcc.com/
"Breaking Cycles; Promoting Wholeness"

CLIENT INTAKE INFORMATION FORM (Please print clearly and answer ALL questions)

Client's Name: _____ DOB: _____M___F___
Spouse or Significant Other or if child/adolescent, Parent's Name(s):
_____DOB: _____
_____DOB: _____
Permission to mail: Permission to call/leave message:
Address: _____Y__N__ Home Phone: _____Y__N__
City/Zip: _____ Work Phone: _____Y__N__
Marital Status: _____ Cell / Pager: _____Y__N__

What is the relationship and ages of the persons who live in the house with you? How well does everyone get along with each other?
_____
_____
_____

Email address: _____

Employer/School: _____ Referral Source: _____

If you are an adult and have children minor or adult, what are their ages and sex?
_____
If you are a child or adolescent, how well do you get along with your siblings; what are the ages and sex of your siblings? _____

Briefly describe the reason(s) for seeking help: _____
_____
_____
Religious/Faith/Spiritual Belief System: _____
Prior Therapy Experience: _____
_____
Place of Employment: _____
Name of Health Insurance: _____ID#: _____
Group # / Name: _____
Primary insured's Name: _____DOB: _____M___F___
Authorization #: _____ Co-Pay: _____
Primary Care Physician's Name/Date of last Appt.: _____
Allergies: _____
Medical Problems:
_____
_____
_____(Use back if needed)
Medications: _____ (Use back if needed)

By signing below, I authorize the release of any medical (PHI) or other information necessary to process an insurance claim. I attest that my therapist will do all that is necessary to file insurance benefits on my behalf, and I authorize payment of medical benefits to my therapist directly. However, as the insured, I am responsible for paying any co-pays due on the date of service. I am also ultimately responsible for any denied claims that were properly filed in a timely manner.

_____ _____
Authorized Signature Date

Revised 08/10/2017 pab

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INFORMED CONSENT AND AUTHORIZATION

PLEASE READ THE FOLLOWING REGARDING MY TREATMENT POLICIES AND SIGN BELOW:

1. **Confidentiality:** All communication between counselor and client is held in strictest confidence unless:
   A. The client authorizes release of information with a signature and waives this privilege.
   B. The counselor is ordered by a court to release information.
   C. Dependent abuse/neglect is suspected or revealed.
   D. The client appears to pose a direct threat to his/her or someone else's life (ex. actively suicidal or homicidal).
   E. Patriot Act

   Note: You will receive a card from me with all of the possible ways for contacting me. Please note that it may take me 24-48 hours to return your call. Individuals may me using technological resources (email, text, fax...) In doing so, they agree to the understanding that cell phone, email and fax communication are not guaranteed confidential methods of communication. ***When used, the client is, by choice, relinquishing their rights to confidentiality.***

2. **Regarding children:** Children (under the age of 18) are only seen with signed permission from a parent/caregiver who has legal custody of the child. Parents have a right to any and all confidential information regarding your dependent with the exception of raw test data. Because the presence of trust is important in the therapeutic relationship between your dependent and me, it is generally best that I do not share specifics of individual sessions with you. However, you have the right and responsibility to question and understand the nature of your dependent's treatment plan, and the progress being made toward treatment goals. If your dependent is able to understand the issue of confidentiality, I will discuss with him/her the type of information that will be shared with you. If you have objections to this manner in which information is shared with you regarding your dependent, we will need to resolve these differences before therapy begins.

3. **Court testimony:** I am not trained in matters that involve the legal system. If required to testify for court, speak with legal counsel, etc. my fee is $180.00 an hour plus mileage and expenses incurred. *I will not testify in divorce custody or mediation***. A two hour minimum is charged.**

4. **Case consultation:** I occasionally consult with colleagues regarding cases in order to provide clients with the best possible care; in these situations I normally do not disclose client names or other identifying information.

5. **Digital Policy**: Individuals may contact their respective therapist using technological resources. In doing so, they agree to the understanding that Skype, phone calls, text messages, email, and fax communications are not guaranteed confidential methods of communication. When used, the client is, by choice, relinquishing their rights to confidentiality. Please be mindful that should you send an email to your therapist, we will review your email at the beginning of the next session. Texting is allowed for scheduling or rescheduling appointments. No clinical dialogue will be shared via text.

6. **Therapy Treatment:** I expect and encourage you to obtain knowledge of the procedures, goals, and possible side effects of psychotherapy. I will try to make our professional relationship one where you will receive the maximum benefit. I will also keep you informed about alternatives to therapy. Therapy may be tremendously beneficial for some individuals. At the same time, there are no guarantees for therapeutic treatment and there are some risks. These risks may include recalling unpleasant events, facing unpleasant thoughts or beliefs, increased awareness of feelings and/or alteration of your ability or desire to deal effectively with others in a relationship. In therapy, major life decisions are sometimes made. As your therapist, I will be available to discuss any of your assumptions, problems or possible negative side effects of our work together. In marital and family therapy, no secrets will be kept among those actively participating in the therapy. If you are using insurance, please note that a diagnosis will have to be provided to your insurance provider in order to submit the claim for payment.

7. **Termination of therapy:** Termination of therapy may occur at any time and may be initiated by you as the client or by me, the therapist. In either event, a final termination session is strongly recommended to explore the termination process itself. This can provide a constructive and useful conclusion to treatment. Referrals or other suggestions will be offered at that time.

8. **A Healing Journey Counseling & Consultation, LLC** is the name for the private practice of Pamela A. Bridgeman, LCSW, who is licensed to practice in the state of Georgia and who abides by the NASW Code of Ethics and several individual therapists who have their practices aligned with A Healing Journey. I encourage you to raise with your individual therapist any concern you may have about the facility, your treatment and billing, or any other issues relevant to the services provided as soon as you become aware of it.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK.
I have read and understand the conditions as stated above. By signing below, I authorize my therapist to begin therapeutic treatment now.

Please provide a person to contact in case of emergency and a contact number here:

Emergency Contact: _____Phone #: _____

Client Signature: _____Date: _____

Therapist Signature: _____Date: _____

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Rights and Responsibilities

Duty of care and commitment to A HEALING JOURNEY COUNSELING & CONSULTATION clients:

Your rights as an A HEALING JOURNEY COUNSELING & CONSULTATION client

As a client of A HEALING JOURNEY COUNSELING & CONSULTATION you can expect to:

- Be treated with respect, dignity and courtesy
- Have your right to privacy and confidentiality protected, within the limits imposed by the law and duty of care
- Have fair and equal access to A HEALING JOURNEY COUNSELING & CONSULTATION services
- Have access to information about your counselling and treatment options and be involved in decision-making regarding these options
- Be able to refuse any, or all, assessment and care that is offered
- Access your records by request, in accordance with the *Privacy Act 1988* and the *Freedom of Information Act 1982*
- Receive services that comply with appropriate standards of professionalism, competency and accountability.

Your responsibilities as an A HEALING JOURNEY COUNSELING & CONSULTATION client

As an A HEALING JOURNEY COUNSELING & CONSULTATION client, you are responsible for:

- Respecting the right of other clients and staff to privacy and confidentiality
- Treating other A HEALING JOURNEY COUNSELING & CONSULTATION clients and staff in a respectful manner
- Ensuring that you are not under the influence of alcohol or other drugs, and/or not behaving in a way which makes delivery of service difficult or dangerous
- Attending appointments and advising the relevant A HEALING JOURNEY COUNSELING & CONSULTATION therapist as soon as possible if you are unable to attend
- Respecting office property
- Honoring agreements made with A HEALING JOURNEY COUNSELING & CONSULTATION about service provision and care.

(Copy to Client)

Protecting your confidentiality and privacy

A HEALING JOURNEY COUNSELING & CONSULTATION is committed to preserving and upholding your rights to confidentiality and privacy.

A HEALING JOURNEY COUNSELING & CONSULTATION records are stored securely and every effort is made to ensure that your counselling sessions and contact with A HEALING JOURNEY COUNSELING & CONSULTATION are confidential. A HEALING JOURNEY COUNSELING & CONSULTATION keeps confidential notes and reports on your counselling and group program attendance so we can provide you with appropriate professional help and for planning and evaluation purposes.

Your clinical information will not be released to any external parties without your consent, unless there are exceptional circumstances where information may have to be released in accordance with the law. This would only occur where your safety or the safety of others is at serious risk, in serious criminal matters, or in response to a court direction.

A HEALING JOURNEY COUNSELING & CONSULTATION are bound by the *Privacy Act 1988* and the Code of Ethics for Social Workers, Licensed Professional Counselors, and Certified Addiction Counselors).

Children and adolescents

A HEALING JOURNEY COUNSELING & CONSULTATION counselling services provided to minors occur with the active involvement of parents in most circumstances.

A HEALING JOURNEY COUNSELING & CONSULTATION generally requires parental permission for the delivery of services to persons less than 18 years of age (Form: A HEALING JOURNEY COUNSELING & CONSULTATION Parental Consent for A HEALING JOURNEY COUNSELING & CONSULTATION to Provide a Service).

The law regards minors as being capable of giving voluntary informed consent to the provision of health services if they have sufficient maturity, usually around the age of adolescence. A HEALING JOURNEY COUNSELING & CONSULTATION requires parental permission for the referral and treatment of all persons under 15 years of age. For adolescents aged 15 – 17 years, other factors, including the young person's maturity and their preferences regarding parental involvement will be considered prior to services being provided.

Young people have the same right to confidentiality in counselling as adults, within the context of parental responsibility. Children and adolescents should be aware that it is A HEALING JOURNEY COUNSELING & CONSULTATION policy to disclose 'relevant' information to parent/s or legal guardians.

In deciding whether to disclose any information about a child or adolescent to their parent/s or other relevant person, the counsellor will take into account the maturity of the minor, the nature of the issues and any statutory or other obligations which may need to be considered, including the safety of the minor and any protection orders that note the interests of the young person. A HEALING JOURNEY COUNSELING & CONSULTATION will inform the young person what information will be disclosed.

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

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(Copy to client)

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Fees and Charges Form

1. **Fees, Charges, and Responsibility for Payment:** Sessions are 45-50 minutes in length. My fee is $100.00 an hour; $125.00 for assessment; please pay in full by cash or debit/credit card before each session, unless arrangements have been made with your insurance company**. It is the client's responsibility to obtain any necessary Authorizations for use of insurance.**

    a. Any insurance co-pays are due at the time of service.
    b. Visa and MasterCard are accepted, as well as Healthcare Spending Account debit cards.
    c. If in extenuating circumstances a check is taken, a fee of $25 plus additional expenses incurred will be applied should your check be returned. You will also be responsible for any expenses incurred to collect unresolved balances.

2. **Contact Procedures:** Sessions are scheduled directly with your therapist. You are required to give at least a 24 hour notice in advance if you are unable to keep a scheduled appointment in order to prevent being billed for the session. You can reach your therapist at 404-334-2493 and leave a voicemail if necessary.

    a. **You will be responsible for full fee payment ($100) if less than 24 hours' notice is given. Insurance does not cover missed sessions.**

3. Forms, Letters and affidavits will incur a $35 per report fee.

By signing below, I attest that I understand that my therapist will do all that is necessary to file insurance benefits on my behalf and I authorize the release of any PHI as necessary to complete the insurance billing process.

However, as the insured, I am responsible for paying any co-pays due on the date of service. I am also ultimately responsible for any denied claims that were properly filed in a timely manner.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Client or Guardian: _____
Minor Child's Name: _____
Client birth date(s): _____

I HEREBY REQUEST AND AUTHORIZE:
Agency: A Healing Journey Counseling & Consultation, LLC
Therapist Name: _____
Address: 650 Henderson Drive, Suite 202, Cartersville, GA 30120
Phone 770-334-2493 ■ Fax 770-334-2675

TO: ____ OBTAIN RECORDS FROM AND/OR _____RELEASE RECORDS TO:
Name/ Agency _____
Address: _____
_____
Phone: _____

To disclose the following specific information:

___ Psychiatric Evaluation ___ Psychological Reports ___ Medical Records
___ Psychosocial History ___ Treatment Plan ___ Labs (incl. Drug screen)
___ Case Records/Reports ___ Other _____

FOR THE PURPOSE OF:
Continuity of care, _____

All information I hereby authorize to be obtained from this individual/agency will be held strictly confidential and cannot be released by the recipient without prior consent. I understand that unless otherwise limited by state or federal regulations and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If not previously revoked, this consent will terminate one year from the date appearing below.

_____ _____
Client/Legal Guardian Signature Date

_____ _____
Therapist/Clinician Signature Date

Date Consent Revoked: _____ Signature: _____