Restoration 23

770.272.2288

CLIENT INFORMATION FORM

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ **Social Security #:** _____

Home street address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Best phone for reaching you or leaving discreet messages. Please indicate any restrictions.

_____

Education: _____ **Highest Degree Obtained:** _____

Occupation: _____

Name of Employer: _____ **Phone:** _____

Spiritual Resources: _____ **Religious Affiliation:** _____

Referred by: _____

- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Briefly describe your concern(s)which prompted you to seek counseling at this time:

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? _____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? (Please remember that this form is completely confidential).

YES NO If YES, what kinds and how often? _____

_____

Previous Hospitalizations: (Approximate dates and reasons):_____

_____

_____

Previous treatment with a psychiatrist, psychologist, or other mental health professional? YES NO

Name:_____Dates:_____Reasons:_____

RELATIONSHIP STATUS:

POOR EXCELLENT

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? _____ How Long? _____ Previously Married/Life Partnered? YES NO

If so, length of previous marriages/committed partnerships_____

FAMILY MEMBERS:

Relationship:	**Name:**	**Age:**	**Describe Relationship**
Spouse/Partner			
Mother			
Father			
Other Primary Caregivers			
Brother(s)			
Sisters(s)			
Children			

Describe any relationship problems you are experiencing at this time:_____

_____

_____

PLEASE CHECK ALL THAT APPLY & *CIRCLE* THE MAIN PROBLEM(S):

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems			Physical Abuse			Depression		
Legal Trouble			Sexual Abuse			Anxiety		
Domestic Violence			Hyperactivity			Psychiatric Hospitalization		
Suicide			Learning Disabilities			"Nervous Breakdown"		

Any additional information you would like to include:

_____

_____

_____

_____

Restoration 23

3950 Cobb Pkwy Suite 604 Acworth, GA 30101

NOTICE OF PRIVACY PRACTICES

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, please let your counselor know.

Effective Date of this Notice	6/6/2010
Contact Person	Libby Watson
Phone Number	404-941-5502

Acknowledgment of Notice of Privacy Practice

*"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way."*

_____

Patient or Representative Name (please print)

_____ _____

Patient or Representative Signature Date

Restoration 23

3950 Cobb Pkwy Suite 604
Acworth, GA 30101

Declaration of Practices

We are pleased that we will be working together, and we are committed to helping you reach your goals in counseling. It is important for you, as a client, to be fully informed about the therapy services you will be receiving. Your signature below indicates that you have received, read, and understand your rights and responsibilities under this agreement and agree to enter a therapy relationship with your counselor upon the terms of this agreement.

The Process of Counseling: It is our desire to provide a warm and trusting environment where you feel free to examine patterns of behavior, thoughts, or emotions that are causing you concern. We see the counseling relationship as one that must be based on mutual trust, respect, and honesty. Goals are established through collaboration with you, the client. We will help you think through possibilities and consequences of decisions, but our role is not to make decisions for you. Assignments may be given to continue the therapeutic process between sessions. It is our hope that you will complete the assignments and view them as a vital part of your therapy. Professional counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. Change is facilitated as the client and therapist establish a mutually respectful partnership.

The therapist will facilitate a process of communication and provide knowledge based on psychological growth and development. It is your obligation to identify personal goals towards which you desire to move and obstacles which may prevent that movement. The purpose of this process is to enable the client to move toward greater psychological health and satisfaction. While the process is effective for many people there are no guarantees of success.

Your first session involves information gathering and becoming acquainted. We will obtain historical information and review the events that brought you in to see us. Feel free to ask any questions you may have. The nature of your need will be discussed and recommendations made concerning future appointments. If the counselor is not a good fit for the client's needs as the counselor determines them to be, appropriate referrals will be made and a second session will not be scheduled.

As Christian counselors, we believe that God loves us and is eager to help in our quest for personal and spiritual growth. We seek God's guidance and use Scripture and prayer when appropriate. It is not necessary that you share our views. We will always respect your personal beliefs and will address spiritual concerns if you express such a desire.

Services Offered and Clients Served: We work with individuals, couples, families, and groups providing services to adults, children, and adolescents.

Potential Counseling Risk: Your participation in outpatient psychotherapy is strictly voluntary and can pose some risk to you. Therapy can involve a wide range of emotions, which may be experienced as both positive and negative. In addition, because of the growth process, you could experience changes in relationships with others that may be a source of strain or difficulty. During the course of treatment, additional problems may surface that you were not aware. If this occurs, please discuss any new concerns with me.

Licensure: Our counselors are licensed by the State of Georgia, through the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists. If your counselor is currently undergoing the process of licensure, she/he will be under the supervision of a Licensed Professional Counselor, as per the Composite Board requirements.

David Arcement, MA, LAPC	License # APC002761
Judy Holley, MA, LPC	License # LPC006519
Trey Mickler, MA, LPC	License # LPC003204
Libby Watson, MA, LPC	License # LPC006514

Qualifications: Our counselors have earned the following graduate degrees:

David Arcement:
- M.A. in Counseling and Guidance from Louisiana Tech University
- M.A. in Marriage & Family Counseling from Southwestern Baptist Theological Seminary

Judy Holley
- M.A. in Professional Counseling from Psychological Studies Institute

Trey Mickler
- M.S. in Counseling from Georgia State University
- Diploma in Christian Counseling from the Psychological Studies Institute

Libby Watson
- M.A. in Professional Counseling from Richmont Graduate University

Code of conduct: As Licensed Professional Counselors and Licensed Associate Professional Counselors, we are required by state law to adhere to codes of conduct for practice that have been adopted by our licensing boards. We ask that you contact your counselor if you have an ethical concern or complaint.

Confidentiality: Information shared by you in the counseling relationship is confidential. We do not disclose client confidences and information to any third party except under the following circumstances in accordance with state law: 1) The client signs a written release of information indicating informed consent of such release, 2) The client expresses intent to harm him/herself or someone else, 3) There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (60 years or older), or a dependent adult, or 4) A court order is received directing the disclosure of information. It is our policy to assert privileged communication on behalf of the

client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. We will endeavor to apprise clients of all mandated disclosures as conceivable.

Fees: Our counselors each set their own fees on a fee-per-session basis. Your counselor will discuss their fees with you prior to your first visit. Most of our counselors do not currently accept insurance cases, but your individual counselor may be able to accept certain insurance plans. Please let your counselor know if you have insurance you would like to use. Your counselor may offer a sliding fee scale based upon financial need. Please discuss any financial hardship you may have with your counselor before or during the first session. A standard session is 45 to 50-minutes in length. If additional time is needed, additional fees will be applied.

If a therapist is subpoenaed to testify or submit records to the court, a fee will be assessed. For a written report a fee of $150 will be charged. Because appearing in court requires cancelling a full day of clients, you will be billed for a full day for each day the counselor is required to report. The fee for the full day is $1000. You will be billed $50 per hour for preparation time. If the court appearance is more than 20 minutes away from the office at which you typically attend sessions, travel expense will also be billed.

If a therapist is contacted by phone by a client, after 10 minutes a fee will be applied comparable to prorated full standard session fees. The client will be responsible for these charges, as they can not be billed to insurance.

Full payment (or insurance co-payment) is expected at the time of the service. You may pay with cash, check or credit card. A $30 charge will be assessed for returned checks. Clients that have not paid for two sessions will be unable to schedule a third session until their account is paid in full. You are responsible for any balance not paid by your insurance.

If a client does not show up for an appointment or provide at least 24 hours notice of cancelling the appointment, a $60 charge will be assessed for the first occurrence. For the second occurrence, a $60 fee will be applied and a third appointment will not be scheduled unless payment is made in advance. Exceptions may be warranted in the event of an emergency.

Client Responsibility: In working to achieve the potential benefits of therapy, it may require that the client make firm efforts to change. This may involve experiencing significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings of fear, anger, depression, frustration, and the like. Seeking to resolve issues between family members, marital partners, and other persons can similarly lead to discomfort, as well as relationship changes that may not be originally intended.

You are responsible for keeping appointments, paying your bill, and following office procedures. In order to receive the most benefit from the counseling relationship it is essential that you are honest and put forth effort in the counseling process. If you have any concerns about the goals and process, it is your responsibility to discuss this with your counselor so that any necessary adjustments can be made. If you are currently receiving services from another mental health

professional, we expect you to inform us of this. If it develops that you would be better served by another mental health provider, we will help you with the referral process.

Physical Health: There is a strong connection between physical and emotional health. As a part of the initial evaluation you will be asked to give the name of your primary care physician, describe your medical history, and list all medications you are currently taking. It is recommended that you have a physical examination if you have not had one in the last year.

Record Keeping: Clients will have a file created in his, her, or their name(s). The purpose of that file is to help the therapist remember relevant information and to carry out his/her responsibilities effectively and efficiently. Files will be maintained for ten years after termination of the counseling relationship at which time the file will be destroyed.

Contact with your Counselor: Clients are requested to contact their counselor by calling their personal number. You may need to leave a message. We strive to return all messages by phone or email by the end of the next business day.

Clients who need to cancel appointments are requested to do so at least 24 hours in advance. This can be done by calling your counselor's personal number.

If for some reason, your therapist must cancel an appointment, he or she will call you at the number you have provided and, if you are not there, will leave a message stating, "This is [your therapist's name] calling for [your name] and I will be unable to keep our appointment today." Every attempt will be made to provide at least 24 hours notice of the cancellation. If you do not want us to contact you in this matter, please notify us so that we can discuss any alternative arrangements.

Emergency Situations: In life-threatening emergencies call 911 or go to the nearest hospital emergency room. If you need assistance before someone is able to return your call, you may call a 24-Hour Crisis Line at (770) 422-0202, seek assistance through the nearest hospital emergency room, or if you are under the care of a psychiatrist, contact his/her office.

I have read the information above and choose to enter into a therapy relationship under the circumstances described.

_____	_____	_____
Client or Authorized Representative	Date	Relationship to the Client

_____	_____
Therapist	Date