Please complete and read both sides of each page, sign where indicated on page 4. If in doubt about signing anything or if you have any questions, I will be happy to discuss them with you in the session.

Today's Date _____/_____/_____ Your Name _____ Sex : M F Age _____

Date of Birth _____/_____/_____ SS# _____ - _____ - _____ Who referred you? _____

Street Address _____ Apt# _____ City _____ State ____ Zip Code _____

Home Ph ( ) _____ - _____ Work Ph ( ) _____ - _____ Cell Ph ( ) _____ - _____
Please tell us if it is NOT okay to call you at any of the above numbers. We will not disclose the nature of our relationship.

Email address (will be kept confidential)_____ ***Email is used only for administrative purposes. Email cannot be used for canceling appointments or as a means of therapy.***

Names and ages of any children living in the home _____

Emergency contact _____ Hm ( ) _____ - _____ Wk ( ) _____ - _____

Employer _____ Position/Title _____ How long employed by this co.?_____
Insurance Information (if applicable)
Name of Company under which claim to be filed_____Member ID# _____
Group/Policy # _____ Co-payment amount $ _____ Deductible amount if applicable $ _____

Information regarding the Primary Insured (if different from the client)
Name of Primary Insured _____ Relationship to you _____ Date of Birth ___/___/___
SS# of Primary Insured _____- _____- _____ Employer of Primary Insured _____

Reason you are seeking help today? _____

Circle the symptoms and /or areas of your life affected by the problems that bring you here today:

Mood Anxiety Sleeping Habits Eating Habits Physical symptoms Concentration problems Temper problems

Marriage/Partner Other Relationships Job/School Performance Financial Problems Legal Problems Other

List any current or chronic medical conditions_____

List any prescription and over the counter drugs/vitamins, herbs, taken in the last 90 days.

_____ dosage _____ # of times per day _____ prescribed by _____
_____ dosage _____ # of times per day _____ prescribed by _____
_____ dosage _____ # of times per day _____ prescribed by _____

List medical providers you have seen in the last 90 days _____
List any allergies _____

Primary Physician Name and phone# : _____ Do you have a psychiatrist also? Yes No
Circle other drugs you have used in the past 90 days: Alcohol Caffeine Nicotine Marijuana

Cocaine Heroin Pain Pills Inhalants Amphetamines/Speed Ecstasy LSD Other

Have you ever had any type of counseling before? ____ yes ____ no. If yes, what year/s? _____

Reason? _____How long? _____ Reason for ending?_____

Have you ever been hospitalized for emotional of mental reasons, including substance abuse rehab? _____yes _____ no
Year _____ Reason _____ Year_____Reason _____

Is there a history of alcohol or drug use in your family? _____ Has a friend, partner or relative discussed concerns about your use? _____ Have you ever been concerned about your drinking or other drug use? _____

CONSENT FOR TREATMENT

Thank you for selecting me as your counselor. The intent of this form is to inform you about the basic treatment relationship between counselor and client, to inform you of basic policies and to help ensure that you understand our professional relationship.

COUNSELING PHILOSOPHY, EXPECTATIONS OF CLIENTS:

I believe strongly in the capacity of people to help their selves and I see our counseling relationship as one in which you are in charge of setting your own goals and I am privileged to travel with you as you work toward attaining your goals. I expect that you will be involved in the counseling process and that you understand that I will work *with* you, not *for* you. My approach to therapy is basically a holistic one: we will discuss your issues from many perspectives and examine the effects on your body, mind, work, spirit, relationships, and any other areas that may be meaningful to you. Your decision to choose to enter counseling is a voluntary one and you may terminate it at any time without penalty. If, in my professional opinion, it is in your best interest to refer you to another therapist, I will do so because ethical standards dictate this course of action. I will provide you with names and numbers of therapists for you to contact, if you wish. Whether you choose to continue counseling with another therapist is entirely your decision. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, we will work together to achieve the best possible results for you. Sessions are **50** minutes in length unless specified in advance. By signing this consent, you agree to begin a counseling relationship. A copy of this informed consent will be provided, and I will be considered your therapist. This relationship will be in effect until termination occurs or until I have not seen you in session for more than 4 weeks from the date of our last scheduled session unless you and I have a prior agreement to leave your case open for a specified amount of time. (see pg 3, under **Termination**)

SCOPE OF PRACTICE, EMERGENCY CONTACT:

I operate an outpatient private practice, and offer individual, family, couples and group therapy. I do not have an emergency practice. Clients are assumed to be self-responsible, autonomous, functioning individuals who are not in need of day to day supervision. I return routine client calls received during office hours within 48 hours. If it is a Friday afternoon or a weekend your 48 hour period begins on the following Monday. On occasion, there may be an unavoidable delay; I appreciate your understanding in this circumstance. When I am out of the office for an extended period of time I will leave detailed information on my voicemail about when I will be returning phone calls.

IN THE EVENT OF AN EMERGENCY:

You can receive 24 hour assistance at Ridgeview Institute by calling **770-434-4567**. If you experience a life or death emergency, you should immediately call **911** or go to your nearest hospital emergency room.

INDIVIDUAL AND COUPLES CONFIDENTIALITY

When I am working with individuals, the individual holds the right to confidentiality. When I am working with couples, I am obligated to preserve confidentiality on behalf of the couple. This means that I will not release information about either member of the couple without the consent of both. This also means that I will not hold individual confidences of either party that will jeopardize my allegiance to or neutrality with both parties in the couple.

CONFIDENTIALITY:

I will keep what you tell me confidential *with the following exceptions as mandated by the law:*

1. You direct/allow me to tell someone else by signing a release of information.
2. I determine you are a danger to yourself or to others.
3. I am ordered by a court to disclose information.
4. You abuse a child or an elderly person
5. If you are under 18 years old and you report you are a victim of physical or sexual abuse.

*Children and adolescents have additional limits to confidentially which will be addressed in the initial assessment. These limits pertain to but are not inclusive of alcohol and drug use, running away, truancy, sex and other safety issues. It is my policy to attempt to communicate with both parents of minor children. A letter will be sent to the parent who is not in attendance at the initial intake. If you have joint legal custody this is mandatory.

CONTACTING YOU:

When I contact you I will attempt to be discreet when identifying myself. If there are special instructions about how to contact you and if a message cannot be left you must let us know. Craig Whitley, my husband, acts as my office manager, and is a fellow therapist in this office. He may make or return phone calls on my behalf. He also helps me with billing and collection issues. Please note if you have caller ID, "Towne Lake Counseling" may appear on your caller ID screen. We contact clients by email occasionally, for scheduling appointments, sending intake forms, statements, and referral resources. Please provide your email address on the intake form in order for me to email you.

ETHICAL GUIDELINES AND STANDARDS:

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards for licensed clinical social workers. If at any time you are dissatisfied with my services, please let me know. I am open to discussing any concerns you may have regarding our work together. If I am not able to resolve your concerns, you may report your complaints to the Georgia Composite Board for Licensed Counselors, Social Workers, and Marriage and Family Therapists. For a copy of the code of ethics to which I adhere, you may contact the above board.

PAYMENT (CHECK, CASH, OR CREDIT CARD) IS DUE AT THE BEGINNING OF EACH SESSION.

****INITIAL SESSION**	**$135 (60 min session) also includes administrative work**
****THERAPY SESSION**	**$100 (50 min session) for Individual and Family Therapy**
****PHONE CALLS: (longer than 10 mins)**	**$1.00 a minute after first 10 mins (first 10 mins at no charge)**
****TIME RE: (NON-SESSION TIME):**	**$100 an hour (Ex.: consultations with others at your request)**
****PAPERWORK TIME:**	**$100 an hour (Ex.: writing reports related to you at your request)**
****OTHER CHARGES:**	**$20 for a check returned for "insufficient funds"**

**Please be aware that I charge for and expect payment for phone time (time after the first 10 minutes) and for non-session time related to you. Payment is due at your next session following the rendering of these services. I will provide a statement for you upon request. If I raise my therapy fee, you will be given at least 60-days notice.

APPOINTMENTS:

I will make every effort to begin and end sessions on time. Your next appointment will be scheduled at the end of each session. Please be mindful of the length of your session as I generally have consecutive appointments and want to be respectful of the next person's time. If you cannot keep your appointment time, you must give me at least a **FULL** 24 hours notice to avoid payment of your scheduled session. If you miss a scheduled appointment without notifying me, you will be charged for the scheduled hour. If you are going to be more than 15 minutes late for your appointment, please let me know by calling **770-517-3363** and leaving a message on my office voice mail. Otherwise, if you are more than 15 minutes late, I will assume you are not coming to the appointment. You will be responsible for the missed appointment and required to pay the whole session fee. Fees for, and lengths of sessions are not pro-rated if you are late. I most likely have another client waiting, since I schedule one client per hour.

INSURANCE:

It is your responsibility, as the client, to obtain any authorizations needed from an insurance company. If the insurance company denies any service it will be your responsibility to pay for these service and attempt to collect reimbursement from the insurance company. As a courtesy to you, I will submit your insurance claims. I will submit any rejected claim a second time. If after the second attempt a claim is denied, it will then be your responsibility to pay me in full and attempt to collect it yourself. I will provide you with the necessary information your insurance company will need.

CONSULTATION:
In keeping with accepted standards of practice and to ensure quality of care, I regularly consult with other mental health professionals regarding clients. Client identity is protected at all times.

RECORDS:
Your file is kept for at least 7 years from first date seen. For minors, this 7 year period begins when you turn 18 years old. Your file contains my copy of this informed consent, your client information form, and all materials that pertain to you, including notes I take. This file is confidential with the exceptions noted in the **Confidentiality section, pg 1.** Your file is protected by two locks and will be destroyed by shredding at the end of seven years.

TERMINATION:
Your decision to enter counseling is a voluntary one and you may terminate counseling at any time you wish without penalty. Termination of the counseling relationship is also a natural occurrence when your goals for counseling have been met. The counseling relationship may also be terminated if, in my professional opinion, it is in your best interest for me to refer you to another therapist, as ethical standards dictate this course of action **(See Counseling Philosophy, page 1.)** Termination will occur automatically if I have not seen you in a counseling session for 4 weeks from the date of our last scheduled session, unless you and I have a prior agreement to leave your case open for a specified amount of time. Should you re-enter counseling with me after your case has been closed, you may be required to complete this paperwork process again and any new changes will apply when you re-enter treatment.

MY PERSONAL STATEMENT AND PHILOSOPHY ABOUT BEING A THERAPIST:
I believe it is crucial for me, as a therapist, to take very good care of myself physically, emotionally, psychologically, educationally, and spiritually. I do this in a number of ways. I believe it is important to balance work, personal and family time and I do my best to practice what I preach by taking care of myself in ways that reflect this belief. This means there will be times when I will not be available. On rare occasions, I may be unavailable for 2-3 weeks at a time. I will inform you of my planned absence in advance. Should you need support during this time, I will provide you with the name and number of another therapist you can contact if you feel the need to do so.

Your signature indicates that you agree to adhere to the policies on all three pages of this "Consent to Treatment" document for Helen T. Whitley, MSW, LCSW.

_____ _____ / _____ / _____
Client Signature **Date**

NOTICE OF PRIVACY PRACTICES FOR THIS OFFICE
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting me or my administrative staff at **(770) 517-3363**.You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I acknowledge I have been offered the right to review the HIPPA "Notice of Privacy Policies".

X _____ **X** _____ _____ /_____/_____
(PRINT) Client Name **Client Signature** **Date**