Donna Still MS, RN, LPC
Master of Science
Registered Nurse
Licensed Professional Counselor

Perspective Counseling Group / 3504 Professional Circle, Ste A Martinez, GA 30907 / Phone: 912-246-0623 / Fax 706-364-8788

Date: _____ **Client's name:** _____ **Gender:** Male Female

Ethnicity: _____ **DOB:** _____ **Age:** _____ **SSN:** _____

Parent/Guardian's name (if applicable): _____ **Relationship to client:** _____
Parent/Guardian's Date of Birth (if applicable): _____
If parents not married/together what is the custody agreement? Sole Joint Other:_____
(Please provide paperwork to prove legal custody)
Who has legal decision-making power for medical/psychological treatment? _____

Client's marital status: _____ **Client's job title/school grade:** _____

Client's employer/school: _____

Client's phone numbers: Home_____ Mobile _____ Other_____

Client's Address: _____City_____ State _____ Zip_____

May we contact you to remind you of appointments? Yes No **May we leave a message?** Yes No

Insurance Plan Name: _____ **Policy number:** _____

Group Number: _____ **Insurance phone numbers (claims/benefits):** _____

Subscriber's name: _____ **Relationship to client:** _____

Subscriber's SSN: _____ **Subscriber's DOB:** _____

Has client ever had psychological testing? Yes No **Approximate dates:** _____
Has client ever had counseling/therapy? Yes No **Approximate dates:** _____
Has client been evaluated by a psychiatrist? Yes No **Name:** _____ **Approx. dates:** _____
Current medications for psychological conditions: _____

Presenting Problem: _____ **Date symptoms began (approximate):** _____

_____ (If client is under 18, parent/guardian signs)

Please present your insurance card when paperwork is collected.

Informed Consent

Consent: I agree to be evaluated and treated by **B. Pris Dearolph, LPC, NCC**

Purpose: I understand that any assessment procedures I receive are for the purpose of clarifying diagnoses and generating a treatment plan.

Withdrawal: I understand that I may withdraw from this evaluation and treatment at any time, and I am free to leave at any time.

Missed Appointments: I understand that if I miss two appointments back-to-back, or miss an excessive number of appointments over time, I may be referred to another facility.

Court/Legal Cases: I understand that my provider does not accept cases that involve the court system, lawyers, DFCS, juvenile justice, custody, or any other legal matters.

Confidentiality: All my personal information will be kept confidential, except:

- My insurance company (if applicable) will receive information about my attendance, my presenting problem, and my diagnosis. The insurance company may require information about why my treatment is necessary.

- My mental health professional is ethically and legally obligated to contact the appropriate authorities or treatment facilities if I give the impression that I am at risk of harming myself or others. If clients under the age of 18 disclose a history or risk of self-harm or other-harm, their parent/guardian will be alerted.

Parents/guardians: I agree that I will not leave any children under 18 unattended in the office, and I will not leave the office while my child is being evaluated or treated.

If client is under 18 years old, the parent/guardian should sign this form.

Print name _____ Signature _____ Date _____

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____

Print Patient Name _____

Signature _____

Relationship to Patient _____

Authorization Consent Form

HIPAA AGREEMENT:

I have read and agree to the Patient Service/HIPAA agreement provided to me by *Thrive Counseling Enrichment and Professional Development*. I have read and understand the Georgia Notice of Psychologist's Policies and Practices. I have read and understand the Patient's Rights and Responsibilities Statement.

Patient Name	Patient (Parent/Guardian) Signature	Date

INSURANCE AUTHORIZATION:

I authorize, *Thrive Counseling Enrichment and Professional Development,* the release of any medical or other information necessary to process medical claims. I authorize payment of medical benefits to be paid to *Thrive Counseling Enrichment and Professional Development* for services provided. *Thrive Counseling Enrichment and Professional Development* will attempt to collect from my Insurance Company; however**, if my insurance company has not paid within 120 days, I (patient) will be billed for the amount the insurance has not paid.**

Patient Name	Patient (Parent/Guardian) Signature	Date

CANCELATION POLICY:

We set aside your appointment time exclusively for you, we ask that you please give a minimum of 24 hours' notice if you need to cancel or change your appointment**. Appointments not cancelled with at least 24 hours' notice will result in a $60 cancellation/no show fee.** Emergencies will be considered and Pris asks that you notify her of these as soon as possible.

Patient Name	Patient (Parent/Guardian) Signature	Date

Notice of Patient Financial Responsibility

Our office provides services in good faith that it will be appropriately compensated. It is the patient's/guarantor's responsibility to understand their individual health policy and its mental health coverage and/or restrictions. Any services not covered by individual health insurance will be the full financial responsibility of the patient/guarantor.

Our office will gladly file with your primary and secondary health insurance on your behalf; but requires that patient financial responsibility is paid in a timely manner. Patients are responsible for letting us know of any changes in insurance coverage or other pertinent demographic information. You must provide our office with a copy of your current insurance card(s) as well as a state issued photo ID or driver's license.

Deductible, copayments and coinsurance are due at the time of service. Outstanding patient balances must be paid prior to new appointments being made.

If the insurance company requests information directly from the patient (*example: accident/incident details*) and the information is not submitted in a timely manner, then the claim will become the full responsibility of the patient/guarantor. Interest, penalty, collection costs and legal costs incurred in order to obtain patient payment become the responsibility of the patient/guarantor.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Georgia Psychology & Counseling.

I authorize payment of medical benefits to Georgia Psychology & Counseling for services.

_____
Patient Name

_____ _____
Patient (Parent/Guardian) Signature Date

Statement of Patients' Rights

Patients have the right to:

- Be treated with dignity and respect.
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Patients' Responsibilities

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and the provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Patient Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

Provider Signature Date

How did you hear about us?

___ My insurance company website.

___ My insurance company call center.

___ Google or other search engine

___ Psychologytoday.com ___ Alltherapist.com

___ Networktherapy.com ___ Healthgrades.com

___ Apa.org ___ Another website: _____

___ A doctor referred me: Dr. _____

___ A mental health facility: _____

___ A lawyer referred me. _____

___ A flyer

___ A magazine

___ A newspaper

___ A family member referred me

___ A friend referred me

___ A coworker referred me

___ My employer/ place of business referred me

___ Other Please describe: _____