New Client Paperwork

Clients Name: _____Date of Birth: _____ Age: _____

Client's SS#: _____Insurance Company: _____ID#: _____

Policy Holder's Name: _____ DOB: _____ SS#: _____

Married___ Divorced ___ Single___ Remarried___ Other_____

Address: _____City, State, Zip: _____

Cell Phone: _____ Work/Home Phone: _____

Employer: _____Position: _____

Referred By: _____

Previous Counseling: ___No ___Yes Clinician's Name: _____

Issues Addressed: _____

Spouse's Name: _____ Cell Phone: _____

Spouse's Address: _____ City, State, Zip: _____

Children (Names and Ages): _____

_____

Please list any physical health symptoms or problems you are having:

___Tired ___Sleep Issues ___Weight Changes ___School/Work Problems ___Loss of Interest

___ Excess Worry ___Self-Injury ___Substance use/Abuse ___Alcohol ___Drugs ___Addictions ___Hopelessness

___Anxiety ___Anger ___Tearful ___Panic/Anxiety ___Suicidal Thoughts ___ Indecisive ___Fearful

Other:_____

_____

Current Medications: Strength How Often Prescribed By Date

_____

_____

Past Medications (If applicable):

_____

Family History: ___Physical Abuse ___Sexual Abuse ___Domestic Violence ___Rape ___Arrests ___Hospitalization

The main issues in my life right now are:

1._____ 2._____ 3._____ 4._____

FOR MINOR CLIENTS:

Parent/Guardian Name: _____

Mother's Information:

Address: _____

City, State, Zip: _____

Cell Phone: _____ Work Phone: _____

Father's information:

Address: _____
City, State, Zip: _____

Cell Phone: _____ Work Phone: _____

Contact in case of Emergency:
Name: _____

Address: _____

City, State, Zip:_____ Cell Phone:_____

Home/Work Phone: _____

Patient Communication Preferences:
Our office will need to contact you to schedule and/or reschedule appointments, to schedule follow-up visits and other such administrative issues. To ensure that your privacy is maintained to the fullest extent possible, please select the method by which our office can contact you.

Cell Phone Calls & Text: _____

Leave Message? ___Yes ___No

Personal email: _____

Home Phone: _____

Leave Message? ___Yes ___No

Work phone: _____

Leave Message? ___Yes ___No

By signing below you agree that you have been given the opportunity to obtain a copy of the HIPAA Notice and that it is your responsibility to ask any necessary questions. In addition, by signing below you also agree to abide by the terms of the treatment agreement and consent to treatment for yourself or your minor.

Signature _____ **Date** _____

_____

Printed Name

Counseling Services of Atlanta, LLC

FINANCIAL AGREEMENT AND PROMISE TO PAY ACCOUNT

For and in consideration of services rendered and to be rendered to _____, I will promise to pay Counseling Services of Atlanta, LLC. I understand that the total charges are due when services are rendered.

For and in consideration of court attendance, I will promise to pay Counseling Services of Atlanta, LLC. I understand that Counseling Services of Atlanta, LLC bills at the rate of $200.00 per hour for court attendance. I agree to provide Counseling Services of Atlanta, LLC with my credit card information. I understand that the hourly rate begins when the therapist leaves the office location. I understand that a fee for two hours will be paid prior to court attendance, ($400.00) and is non-refundable if less time is needed. If the court attendance exceeds two hours, I understand that my credit card will be billed for the remaining time. In addition, I understand that I am not paying for the therapist testimony; I am paying for their time. Therefore, the fees are expected to be paid regardless of whether the therapist testifies or not. _____ (initial)

I understand that my credit card will be charged for any time that my therapist has to spend dealing with legal issues (responding to subpoenas/ court orders, phone conversations, letter writing, etc.). I understand I hold COMPLETE financial responsibility for any legal fees that my therapist incurs due to myself or my **MINOR** child (even if I am not the one making the request). I understand that ALL fees will be paid prior to my therapist responding to any legal issue and that I am paying for my therapist TIME and not RESPONSE. I understand that my credit Card will be charged a minimum of $50.00 for any communications and any time that exceeds 30 minutes will be charged an additional $50.00 _____(initial)

I understand that I am financially responsible for missed appointments, in which I do not give a 24-hour notice. Notice must be given via phone call. The fee for a missed visit (in which less then 24-hour notice is not given) is $75.00. This fee will be expected upon arrival of your next visit or charges to the credit card on file, before services are rendered. _____(Must initial)

I understand that I am financially responsible for all charges at the time services are rendered. I understand if I do not pay the entire amount due to Counseling Services of Atlanta, I hereby agree and give my permission to Counseling Services of Atlanta, LLC, to seek legal action to receive payment for services rendered and or work with CSA's collection agency to resolve payment. I understand that I will be responsible for paying the collection and/or legal fees should my account be turned over to collections. I also agree that in the event it is necessary to retain an attorney to enforce the terms of this agreement, relative to payment of fees, Counseling Services of Atlanta shall be entitled to reasonable attorney fees and cost of collection._____(initial)

Please provide us with your credit card information. The card will ONLY be charged if less than 24 hr notice is given to cancel an appointment or on accounts in which insurance did not pay or a balance is due.

Type of Card (Only Accept Visa & MC): Mastercard Zipcode:

Name as it appears on card: Expiration:

Card#: 3 Digit Security Code:

By signing below I am agreeing to the terms and conditions of this financial contract.

_____ _____

Signature Date

Telehealth Consent Form

Counseling Services of Atlanta, LLC

Phone 678-444-4505

Secure FAX 678-606-9316

Website www.counselingservicesofatlanta.com (https://www.counselingservicesofatlanta.com)

NOTE: This is the patient's name. If you are filling this form out on behalf of your child or the patient, please be sure to use the patient's name, NOT your name.

CLIENT NAME (Printed): _____

Patient's Date Of Birth: _____

Consent to TeleMental Health Treatment

Telemental health involves the use of electronic communications to enable providers to engage in clinical mental health services when the client and provider are at different locations and may include Live two-way audio and video.

- Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to care, reduced travel time, and allows a patient to participate in therapy from whatever environment they feel most comfortable.

Possible Risks:

Potential risks associated with the use of telemental health include, but may not be limited to:

- Disruption of transmission by technology failures;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information; Limited ability to respond to emergency situations;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telemental health, and that no information obtained in the use of telemental health which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemental health in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there will be no recording of any of the online sessions by either party. All the information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization except where the disclosure is permitted and/or required by law.
4. I understand that a variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time.
5. I understand that telemental health may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state.
6. I understand that I may expect the anticipated benefits from the use of telemental health in my care, but that no results can be guaranteed or assured.
7. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that it is my responsibility to let my provider know.
8. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health sessions are not appropriate and other care is required.
9. I also understand that telemental health may not be the most effective form of treatment for certain individuals or presenting problems. If the provider believes that the patient would benefit more from another type of service, such as face to face sessions, or from another provider, a referral will be made.
10. I understand that during my session I should be in a quiet private place and should not be driving or operating machinery.

Are you the patient or parent/guardian of the patient? (Check One)* Patient _____ Parent/Guardian _____

Patient Consent To The Use of Telemental health

I have read and understand the information provided above regarding telemental health. I hereby give my informed consent for the use of telemental health in my care.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Patient Consent To The Use of Telemental health

I have read and understand the information provided above regarding telemental health. I hereby give my informed consent for the use of telemental health for the patient's care.

Parent/Guardian Printed Name: _____

Relationship to Patient: _____

Parent/Guardian Signature: _____ Date: _____

Assumption of Risk and Waiver of Liability for Coronavirus/COVID-19

Counseling Services of Atlanta, LLC

Phone 678-444-4505

Secure FAX 678-606-9316

Website www.counselingservicesofatlanta.com (https://www.counselingservicesofatlanta.com)

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. It is a potentially deadly disease that can result in death or permanent injury. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Counseling Services of Atlanta LLC offers telemental health treatment options to help prevent the spread of COVID-19. Counseling Services of Atlanta has also put in place preventative measures in its facilities to reduce the spread of COVID-19. However, the Counseling Services of Atlanta LLC cannot guarantee that you or your child(ren)/guardian(s) will not become infected with COVID-19. Further, attending in-person appointments with your therapist could increase your risk and your child(ren)'s/guardian's or guardians' risk of contracting COVID-19.

By signing this agreement, I understand and agree to the following:

1. By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that myself and/or my child(ren)/guardian(s) may be exposed to or infected by COVID-19 by attending in-person appointments with my therapist at Counseling Services of Atlanta LLC and that such exposure or infection may result in personal injury, illness, permanent disability, and death.
2. I understand that telemental health treatment options are available through Counseling Services of Atlanta, and I have voluntarily declined to use those services and have opted for an in-person appointment.
3. I understand that the risk of becoming exposed to or infected by COVID-19 at Counseling Services of Atlanta LLC may result from the actions, omissions, or negligence of myself and others, including, but not limited to Counseling Services of Atlanta LLC, their contractors, their employees, volunteers, and other participants and their families.
4. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and/or my child(ren)/guardian(s) (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren)/guardian(s) may experience or incur in connection with my attendance or my child(ren)'s/guardian's or guardians' attendance at in-person appointments at Counseling Services of Atlanta LLC.
5. On my behalf and/or on behalf of my child(ren) or guardian(s), I hereby release, covenant not to sue, discharge, and hold harmless Counseling Services of Atlanta LLC, its contractors, its employees, agents, and representatives of and from the claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto.
6. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Counseling Services of Atlanta LLC, its contractors, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any in-person appointments at Counseling Services of Atlanta LLC.

_____	_____
Printed Name of Patient	Patient Date of Birth (MM/DD/YYYY)
_____	_____
Signature of Patient/Parent or Guardian	Date Signed
_____	_____
If Parent or Guardian Print Name	If Parent or Guardian Relationship to Patient

Counseling Services of Atlanta, LLC
376 Powder Springs Street, Ste. 240A, Marietta, GA 30064
1521 Johnson Ferry Rd, Ste. 110, Marietta, GA 30062
4006 Holcomb Bridge Road, Suite 210, Norcross, GA 30092
1215 Hightower Trail, Building D, Suite 102, Sandy Springs, GA 30350
678-444-4505 phone, 678-444-4506 fax
www.counselingservicesofatlanta.com

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION AND RECORDS

I, _____(Your Name)
authorize Counseling Services of Atlanta, LLC to release/obtain records or communicate with:_____
concerning _____(Name: myself, child, other)

I understand that under Georgia Law, communication between a client and his/her counselor is privileged and may not be disclosed by the counselor unless the client consents. I also understand that client records maintained by a counselor cannot be disclosed to a third party except with the client's consent through the legal process. The only time the above is not in effect is when there is threat of danger or what is required by law. This authorization also allows the discussion of my case with a colleague, or an appropriate state agency. I also agree to pay any reasonable cost. This authorization shall remain in effect until revoked by me in writing.

This _____day of _____, 20____.

_____
Signature of client or parent/guardian of minor child

_____
Witnessed by Date