*Georgia Professional Counseling Center, Inc.*
*602 Abbey Court, Alpharetta, GA 30004*

Adult Client Questionnaire (Client ages 18 and over)

To be completed by the client requesting services.

This, as well as other communications with your evaluator, will be kept confidential to the full extent of Georgia law.

**Identifying Information:**

Date:____________________

Name:_______________________________________DOB:___________Age:_____

Home Address:______________________________________________________________
City, State, Zip

Home Phone:__________________
Work Phone:___________________ Cell Phone:__________________

May we leave a message at Home? Y * N
Can you be contacted at work? Y * N

Employer:______________________________Occupation:__________________

Marital Status:_________________________Anniversary Date:_________________
Day/Month/Year

Spouse/Partner's
Employer:____________________Occupation:________________________

If Divorced, for how long:____________Number of Marriages:_______

Referred by:
__________________________________________________________________

Address, if known:
__________________________________________________________________

May we mail a thank you letter to your referral source? Y * N

**Billing Information:**

Party Responsible for Payment:__________________________
Relation to Client:________________

**Family Information:**

| | Name | Age | Living with You? |
|---|---|---|---|
| Spouse/Partner | | | Y or N |
| Children | | | Y or N |
| | | | Y or N |
| | | | Y or N |
| | | | Y or N |
| Your Parents | | | Y or N |
| | | | Y or N |
| Your Siblings | | | Y or N |
| | | | Y or N |
| | | | Y or N |
| | | | Y or N |

Others living with you:______________________________

Education:______________________________

Spouse/Partner's Education:______________________________

Religious affiliation:______________________Active________Inactive________

How significant is religion to your everyday life?
______________________________

Military Service:______________________________

Describe any physical problems you or members of your household have which require medication or physical care:
______________________________
______________________________
______________________________

List any medications you take – prescription or over the counter:

________________________________________________________________
____________________________________________________
________________________________________________________________
____________________________________________________

Do you have any allergies or adverse reactions to medication?

________________________________________________________________
____________________________________________________

The following is a list of problems people commonly have. Read each one carefully and circle the number to the right that best describes how much that problem is of concern to you.

0 – Not at all 1 – Mildly 2 – Moderately 3 – Very Much 4 – Extremely

| | | | | | |
|---|---|---|---|---|---|
| 1. Feeling low in energy or slowed down | 0 | 1 | 2 | 3 | 4 |
| 2. Dissatisfied with my spiritual life | 0 | 1 | 2 | 3 | 4 |
| 3. Repeated, unwanted thoughts that won't leave my mind | 0 | 1 | 2 | 3 | 4 |
| 4. Loss of control, or fear of losing control of my temper | 0 | 1 | 2 | 3 | 4 |
| 5. Not satisfied with my weight or appearance | 0 | 1 | 2 | 3 | 4 |
| 6. Nervousness or shakiness inside | 0 | 1 | 2 | 3 | 4 |
| 7. Troubled by sexual thoughts or behavior | 0 | 1 | 2 | 3 | 4 |
| 8. Drink when troubled or under pressure | 0 | 1 | 2 | 3 | 4 |
| 9. Unusual fears that most people don't have | 0 | 1 | 2 | 3 | 4 |
| 10. Thoughts of ending my life | 0 | 1 | 2 | 3 | 4 |
| 11. Sleep that is restless or disturbed | 0 | 1 | 2 | 3 | 4 |
| 12. Problems with police or legal matters | 0 | 1 | 2 | 3 | 4 |
| 13. Feel withdrawn and/or isolated | 0 | 1 | 2 | 3 | 4 |
| 14. Loss/absence of sexual desire or pleasure | 0 | 1 | 2 | 3 | 4 |
| 15. Other people being aware of my private thoughts | 0 | 1 | 2 | 3 | 4 |
| 16. Feeling hopeless about the future | 0 | 1 | 2 | 3 | 4 |
| 17. Problems with my eating | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|---|---|---|---|---|---|
| 18. Spells of terror or panic | 0 | 1 | 2 | 3 | 4 |
| 19. Feeling shy or uneasy with the opposite sex | 0 | 1 | 2 | 3 | 4 |
| 20. Drinking or emotional problem in my family | 0 | 1 | 2 | 3 | 4 |
| 21. Feeling that others are watching or talking about me | 0 | 1 | 2 | 3 | 4 |
| 22. Things about my life that are too painful to talk about | 0 | 1 | 2 | 3 | 4 |
| 23. Difficulty feeling close to another person | 0 | 1 | 2 | 3 | 4 |
| 24. Problems dealing with stress or anxiety | 0 | 1 | 2 | 3 | 4 |
| 25. Sadness or tearfulness | 0 | 1 | 2 | 3 | 4 |

In the past, have you ever been the victim of or witnessed any type of traumatic event or incident? If yes, please explain:

______________________________________________________________________
__________________________________________________________
_______________________________________________________________

Is there anything else which you feel or believe that may be important for your therapist to know?

_______________________________________________________________
_______________________________________________________________
______________________________________________________________________
__________________________________________________________

Primary Physician or other health care provider:

______________________________________________________________________
__________________________________________________________

Office address and telephone:

______________________________________________________________________
__________________________________________________________

**Authorization for evaluation:**

I authorize evaluation to be administered by Georgia Professional Counseling Center, Inc.

**Client**
**Signature:**______________________________________**Date:**___________

CLIENT NAME: ______________________________________________Age: ____________

**Georgia Professional Counseling Center, Inc.**
**Statement of Understanding**
**Client's Rights and Responsibilities**

TO BE SIGNED BY THE RESPONSIBLE PARTY FOR THIS CLIENT

**Program Description:** Georgia Professional Counseling Center, Inc. is staffed by trained and experienced psychotherapists. Our staff's goal is to provide quality, caring and professional services to our clients and their family, regardless of the client's race, ethnic origin, religion, creed, gender, age disability status, or sexual orientation.

## CLIENT RIGHTS

**Confidentiality:** Everything you say to your therapist is confidential and cannot be shared with anyone outside this office without your permission. Your therapist cannot release any information about you without a signed *consent for release of information*, except in emergencies or when there is a court order, determination or law requiring the information be released. By my signature below, I agree not to hold Georgia Professional Counseling Center, Inc. liable for such disclosure.

**Duty to Warn:** Information about dangerous behaviors, including serious thoughts of hurting yourself or another person, as well as information about possible child abuse, is not confidential and will be reported by your therapist to the appropriate authorities to keep you and other people safe. Also, if you are referred to counseling by a court order, information about your treatment is not confidential and can be released to the Court without your consent.

**After Hour Emergencies:** Georgia Professional Counseling Center, Inc. **DOES NOT** provide 24-hour coverage for client emergencies. If a life-threatening emergency should arise after hours, you should call 911 or travel to the nearest emergency room. If you need to talk to a counselor urgently but the need is not life threatening, you may call the Georgia Professional Counseling Center, Inc. main number (404-915-7106) during office hours (Monday through Friday 10AM to 7PM).

**Appointments:** You are responsible for confirming and rescheduling your next appointment date and time.

**24-HR Cancellation Policy:** 24-hour notice is required for cancellations, since your therapist reserves time for you when you schedule an appointment. If you do not cancel **24 hours in advance**, **you will forfeit your $200 payment.** ***NOTE:*** You may leave a message on the Georgia Professional Counseling Center, Inc. main number (404-915-7106) during or after regular business hours and on weekends to cancel an appointment.

**Missed Appointment Charge: You will forfeit your $200 payment** for a missed appointment.

**Fee Payment:** You are responsible for paying your session fee unless other payment arrangements have been made with your therapist. Billed balances are due upon request for payment.

**Collection of Delinquent Accounts:** A delinquent balance will be cause for your account to be classified as a bad debt and forwarded to a collection or legal agency for immediate action. Any charges incurred by Georgia Professional Counseling Center, Inc. for the collection of the delinquent balance will be your responsibility. In the case of a Court Order, determination, or law requiring the account information be released, my signature below states that I agree not to hold Georgia Professional Counseling Center, Inc. liable for such disclosure.

**Returned Check Charges:** Your account will be charged a **$75 returned check fee** for NSF checks. This fee and the outstanding balance will be due upon request.

**Timely Notification of Changes:** You are responsible for notifying our office of any change in your address, telephone number, employment and insurance carrier information prior to your next appointment.

*My signature below indicates that I have been informed of my rights and responsibilities, and that I understand this information. I understand that it is my sole responsibility to request clarification or additional information concerning my rights and responsibilities.*

___________________________________________________________________

*Signature of Client / Parent / Legal Guardian / Other* *Date*

*Address:* ____________________________________________________________

*State:* ________________*ZIP:* _______________*Tel:* ___________________________

*Employer:* ________________________________*Tel:* ___________________________

**Georgia Professional Counseling Center, Inc.**
**SELF-PAYMENT AGREEMENT for Anger Evaluations**

**Responsible Party Information:**
**I,**_______________________________________________________________
PRINT FULL NAME
am the responsible party for:
_______________________________________________________________
PRINT CLIENT NAME

**Identifying Information:**
Date:____________________

Name:_____________________________________DOB:________________Age:_____

Home Address:___________________________________________________________
City, State, Zip
Home Phone:__________________
Work Phone:___________________ Cell Phone:__________________

I am aware that a payment of **$200.00** will be made before the Anger Evaluation is rendered. Initial here to acknowledge you agree_____.

I am aware that if this is mobile evaluation, that is if it is done at my home or office, there is an additional **$100 charge**. Initial here to acknowledge you agree____.

I am aware that payments may be rendered via Cash or Check. Initial here to acknowledge you agree_____.

**24-Hour Cancellation Policy:** 24-hour notice is required. If I do not cancel 24 hours in advance, **I will forfeit my $200 payment.** Charges are due upon request for payment. Initial here to acknowledge you agree_____.

**Missed Appointment Charge: I will forfeit my $200 for a Missed Appointment.** I am responsible for notifying Georgia Professional Counseling Center, Inc. Charges are due upon request for payment. Initial here to acknowledge you agree_____.

I am aware that I am responsible for notifying Georgia Professional Counseling Center, Inc. of any changes in my mailing address, telephone numbers and employment. Initial here to acknowledge you agree_____.

I am aware that in the event of default of payment on this account, my account may be turned over to an outside collection agency or legal representative for collection. Any additional costs incurred by Georgia Professional Counseling Center, Inc. to collect the outstanding balance will become my responsibility. Initial here to acknowledge you agree_____.

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

**Signed:** _____________________________________ **Date:**

**Effective 01/01/2006**
**Georgia Professional Counseling Center, Inc. Policies and Practices to Protect the Privacy of Your Health Information**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

## II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

- *Adult and Domestic Abuse* – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

- *Health Oversight Activities* – If I am the subject of an inquiry by the Georgia Composite Board of Licensed Professional Counselors, I may be required to disclose protected health information regarding you in proceedings before the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

- *Worker's Compensation* – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

## IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you with a revised notice via U.S. regular mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact John H. Pruett, Jr., Compliance Officer, at 770-656-9711.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to the attention of your therapist's name c/o John H. Pruett, Jr., Compliance Officer at Georgia Professional Counseling Center, Inc. at 602 Abbey Court, Alpharetta, GA 30004.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 1st , 2006.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by U.S. Regular Mail.

Print Client Name: ________________________________________________

________________________________________________________________

Signature                                                                                    Date

Patient (18 Years and older) / Legal Guardian

_______________________________________________
Print Name
_______ I would like a copy. ________ I decline a copy of this document.