Life Clarity Group, LLC
Clear Choices for Life Moments

Client Information		
Last Name	First Name	MI
Preferred Name	Date of Birth	Form Completed by (other than client)
Social Security Number	Gender:	Race/Ethnicity:
Grade in School	School	
Street Address		
City	State	Zip
Phone	Leave message Yes □ No □	
How Did you hear about us?		
Emergency Contact Name	Relationship	
Emergency Contact Phone Numbers		

Parent(s) Information		
Name	Date of Birth	
Employer, Occupation, Education	Living with? Yes □ No □	
Contact number:	Email:	
Name	Date of Birth	
Employer, Occupation, Education	Living with? Yes □ No □	
Contact number:	Email:	

Intake Questions
Have your previously received counseling? If so, name of provider.
Are there any spiritual or religious beliefs we should be aware of?
List any medical problems and medications
What is your Primary Physician Name and Number?
What brings you in today?

Billing Information - copies of photo id and insurance card (if applicable) needed at intake	
EAP Company Name	Insurance Company Name:
EAP Contact Number	Member ID
Authorization Number	Group ID
Employee Name	Insurance Contact Number

Employee DOB	Policy Holder Name and Relationship to Client
Relationship to Client	Policy Holder DOB and SSN
Company Authorizing Benefits	Policy Holder Street Address
Number of Sessions Authorized	City, State, Zip Code

Privacy Policy Acknowledgement Statement
I hereby acknowledge that I have been made aware that Life Clarity Group has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability ACT of 1996 (HIPAA).
As a client of Life Clarity Group, I understand and acknowledge the following:
1. Life Clarity Group has a privacy policy in effect in their office.
2. Life Clarity Group has made this policy available to me for review, by placing a complete version on their website and/or by having a copy available upon request in office.
3 Life Clarity Group has made me aware that I am entitled to a copy of this privacy policy if I desire a copy for my personal file.

Upon review of the above statements, please sign below acknowledging that you have been advised of the privacy policy implemented by Life Clarity Group and have read and understood the acknowledgement form. If you desire a copy of the Privacy Policy, please request one at this time.
___ No, I do not want a copy, but acknowledge the Privacy Policy exists.
___ Yes, I do want a copy of the Privacy Policy

Patient Agreement for Communication
I understand that as part of my healthcare Life Clarity Group will need to contact me in order to remind me of an appointment or provide other information.
I authorize Life Clarity Group to contact me in the following ways (check those which you authorize):

_____ Home phone _____Work Phone _____Cell Phone _____Email _____Mailing Address

Life Clarity Group does not use secure server for appointment reminders. However emails sent directly from the therapist utilize a secure server which may require you to enter a password to access the contents. Please check your spam folders frequently to verify whether an email has been received.

I understand that Life Clarity Group will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications. My signature below indicates that I am consenting to treatment at Life Clarity Group, LLC and have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPAA). If I have questions, the information has been explained and/or summarized for me.

I authorize Life Clarity Group, LLC. to release any medical information to my insurance company which may be deemed necessary in order to process an insurance/EAP claim. I authorize my insurance/EAP company to assign benefits to Life Clarity Group, LLC. I understand that I am responsible for payment for services rendered by Life Clarity Group, LLC. regardless of reimbursement for these services by the insurance/EAP company and that any inaccuracy in information on this form may result in nonpayment by my insurance/EAP company. I agree to notify Life Clarity Group, LLC immediately whenever I have changes in my health condition, employment status or health plan coverage in the future.

Minor Consent and Agreement	
Clients Name	Date of Birth
Parent/Legal Guardian Name	Contact number
Parent/Legal Guardian Name	Contact number

Minor Consent	
Please check below to indicate the current situation regarding the custody of the minor child:	
□ Parents are married to each other and are the legal parents of the child *(one signature required)*	□ I am a single parent and have full legal custody of the child *Provided copy of custody agreement*
□ My ex-partner/spouse and I share legal custody of the child *(both signatures required) Provide copy of custody agreement* □Will he/she agree to treatment of the child? □ Yes □No	□The child is in the custody of the State of Georgia. County_____ *Provide copy of guardianship paperwork and DFCS representative contact information.*

□I understand that at least one parent must accompany the minor child to his/her first appointment and any subsequent appointments, until discussed with and agreed upon with the therapist.
□I understand that Life Clarity Group, LLC does not give recommendations or do evaluations for child custody or parenting. If this becomes an issue, my child's case may be closed.
□I hereby grant my permission for my minor child to be treated by Life Clarity Group, LLC. This permission will remain in force until revoked by me.

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Very often, it is best to see them with parents and other family members; sometimes, they are best seen alone. The therapist will assess which might be best for your child and make recommendations to you. Obviously, the support of all the child's caregivers is essential, as well as their understanding of the basic procedures involved in counseling children.

The general goal of involving children in therapy is to foster their development at all levels. At times, it may seem that a specific behavior is needed, such as to get the child to obey or reveal certain information. Although those objectives may be part of overall development, they may not be the best goals for therapy. Again, the therapist will evaluate and discuss these goals with you.

Because of the role is that of the child's helper, the therapist will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. *Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.*

The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, at the same time that parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and of the child in therapy.

I will do my best to ensure that therapy sessions are attended and will not inquire about the content of sessions. If my child/children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Basically, unless my child/children report abuse or there is a clear danger to self or others, the therapist will normally tell me only the following: whether sessions are attended, participating or if progress is being made.

Signature of Client(s) or Personal Representative: _____

_____

_____

Relationship to Patient if Personal Representative:_____

Date of Signature: _____

COUNSELING POLICIES AND CONSENT TO TREATMENT

Thank you for choosing Life Clarity Group, LLC. We realize that starting counseling is a major decision and you may have many questions. If you have any questions or concerns, please ask and we will try our best to give you all the information you need.

THERAPY

Therapy is not easily described in general statements. It varies depending on the particular problems that the clients bring, the training of the therapist, and the personalities of the clients and the therapist. Unlike a visit to a medical doctor, therapy requires hard work on the clients' part. In order to be successful, the client will have to put a lot of effort into their sessions and a lot of effort into the time between sessions.

Therapy has both benefits and risks. Research has shown that two-thirds to three-quarters of clients find their therapy quite helpful. Therapy often leads to a significant reduction of distress, better relationships, and resolution of specific problems. Unfortunately, since therapy is not an exact science, there can be no guarantees about what each client's experience will be.

The risks of therapy include feelings of frustration, fear, anger, and sadness. Things that are difficult to discuss may also come up. Therapy will also probably involve making some changes in habitual ways of doing things – and this may feel difficult at first. Therapy may involve recalling unpleasant aspects of your life and life history. Also, you may have new insights into yourself and others that may initially feel uncomfortable.

All counseling or therapy begins with some type of evaluation process or period of time. During this evaluation period, you and your therapist will determine if he or she can help you with the issues you are bringing to therapy. Goals will be discussed and your therapist will create a plan to assist in achieving these goals.

APPOINTMENTS

Appointments generally last approximately 45 minutes in length. If you need to cancel or reschedule your appointment, we require a minimum of 24 hour notice; otherwise, you are subject to a charge of $40 for the missed appointment. Our counselors will do their best to be punctual for your appointment unless they have an emergency. We ask that you be punctual as well. If you are late, for any reason, you will only receive the remainder of your scheduled time. This is necessary so we can see following clients at their scheduled time. You will, however, be required to pay the full fee. Of course, in the case of an emergency or illness, late cancellations are acceptable per your counselor's approval.

CONTACTING US

Therapists are often not immediately available by phone due to their work with clients. Please be aware that therapists have a very limited amount of time to respond to clients between sessions. Please only contact your therapist for response between sessions if the information cannot wait until your next scheduled session. You may contact us by phone or by email. Please be advised that your therapist may return your call by utilizing a cellular phone. There are risks associated with cell phones (others overhearing the signal, etc.) however your therapist will do his or her best to maintain your confidentiality. If you prefer for your phone calls to be returned using an alternative method, please inform your therapist. If utilizing email, the inclusion of therapeutic information will be limited in case of a wireless breach. If you are not comfortable with e-mails, you are free not to utilize this option.

If an emergency arise and you cannot wait to hear back from your therapist, you may contact: Crisis Line: (800) 715-4225, Summit Ridge (678) 442-5800, call 911, your physician or visit your local emergency room

Discontinuation of Treatment: Either of us may elect to discontinue treatment at any time. It is desirable to have a final closing session if a decision to discontinue to treatment is made. If the decision to discontinue is made, I will be glad to provide you with names of other referral sources if you so desire. However, after 30 days of no contact, the Therapist may elect to close a client's file. A client may contact the therapist to reopen a file at any time however reauthorization from any third party payers may be needed.

Transfer Plan: In the unlikely event that we are unable to provide ongoing services, Port of Peace Counseling will provide those services and will maintain your records for a period of 7 years. Port of Peace Counseling may be contacted at 404-987-9099.

Confidentiality
The staff and therapists at Life Clarity Group, LLC have an obligation to respect your right to confidentiality for the information you share within this clinical setting. Confidentiality of client information is governed by federal law (HIPPA) and by state law. There are some situations in which your therapist would be legally obligated to take action to protect others from harm, even if information about a patient's treatment has to be revealed.

Risk of Self-Harm: If your words or behaviors convince your therapist that you are likely to harm yourself, either deliberately or because you are unable to keep yourself safe, your therapist must do whatever he or she can do to prevent you from being harmed. This means the therapist must take action, up to but not limited to, hospitalization with or without your consent. In the event hospitalization is needed, the therapist would involve another mental health professional that is capable of performing a 1013 temporary hold order for evaluation or call 911 and the local police would be involved. If this situation arises, your therapist will discuss it with you before taking action unless it appears that this would be unsafe or immediate action is needed to keep you from being harmed. **Initials** _____

Risk of Harm to Others- If you threaten to harm another person, your therapist must try to protect that person at all cost. Your therapist would report your threat to the police, warn the threatened person, and try to prevent you from carrying out your threat. If this situation should arise, your therapist will discuss it with you before taking actions unless it appears that this would be unsafe or immediate action is needed to keep you from acting on your threat. **Initials** _____

Emergencies- In the event of an emergency where your health or life is endangered, your therapist must provide medical personnel or other professionals any information about you that is needed to protect your life, however, only information that is pertinent to that purpose. If possible your therapist would discuss such actions with you prior to disclosure and obtain your permission. If this is not feasible, the therapist will discuss any information that was released at a later time. **Initials** _____

Abuse- If your therapist obtains information leading them to believe or suspect that someone is abusing a child, a senior citizen, or a disabled person, the therapist must report this to the appropriate state agency including Department of Family and Children Services (DFACS) and/or Adult Protective Services. To "abuse" another person means to neglect, hurt (physically or emotionally) or sexually molest or be sexually inappropriate in any manor to another person. The therapist cannot investigate and decide whether abuse is taking place: if the therapist has suspicion they are mandated and must report the suspicion to the appropriate authorities. The state agency will investigate the situation and take the appropriate steps to rectify the situation. **Initials** _____

Legal Proceedings- If a judge orders your therapist to provide information about your history or your treatment, the therapist must disclose only the specific information that is requested to the judge/court system. **Initials** _____

Professional Consultation: The therapist may consult with a clinical supervisor or another colleague about your treatment. In these consultations, the identity of the client will not be revealed. The therapist will usually inform clients of these consultations. **Initials** _____

THERAPY OF CHILDREN, FAMILIES AND COUPLES: ***CHECK IF NOT APPLICABLE*** _____

Children and Adolescents- It is the policy of this agency, when a therapist treats children and adolescents, to ask their parents or guardians to agree that most details of what their child(ren) or adolescent(s) tell the therapist will be treated as confidential, however, parents or guardians do have the right to general information about how the therapy is going. The therapist may also have to advise parents or guardians about information if their children or others are in danger. If this situation arises the therapist will discuss it with the child or adolescent first before talking to the parents or guardians. (Please see Minor Consent for more detailed information). **Initials** _____

Families- At the start of family therapy all participants must have a clear understanding of any limits on confidentiality that may exist. The family must also specify which members of the family must sign release of information forms necessary for the records of family therapy (including authorization disclosure of information about the families' history or prior treatment). **Initials** _____

Couples- If one member of a couple tells the therapist something the other member does not know, and not knowing this could result in harm to either party, the therapist cannot guarantee confidentiality from the other person. If this situation should arise the therapist will discuss the situation thoroughly with the informing party prior to disclosing unless immediate impending danger may result to either party.
Initials _____

EAP ONLY

- EAP services include an assessment and referral for issues that cannot be resolved in the allotted EAP sessions or short term counseling. Not all issues are EAP appropriate. Your therapist will inform you if your presenting issue will not be appropriate for EAP and will offer alternatives.

- No paperwork can be given to the employee from the EAP counselor. All paperwork requests, to include but not limited to disability requests, FMLA, etc. must go through the EAP Company.

- In most cases, EAP clients cannot be charged a missed appointment fee. Instead, clients will lose a session authorized for any missed appointments.

INSURANCE & EAP BILLING

- We are in-network providers for several EAP and insurance companies. As a courtesy to you, we work directly with your primary insurance and will make every effort possible to bill your insurance company. EAP companies are routinely billed as the nature of the practice.

- Verification of benefit coverage is not a guarantee of claim payment. All benefits are subject to the terms and conditions (e.g. authorizations, network requirements) outlined in your member contract with your insurance company. We have no authority to make representations to you regarding coverage of items or services covered.

- It remains your responsibility to pay any deductibles, copayments or other amounts your insurance carrier determines as payable by you – this is to be collected by your therapist at each session. Your insurance company informs you of the amount payable by sending you an explanation of benefits (EOB) at the same time that we are informed of this amount. Should you need a statement or payment itemization, please inform your therapist, and we will provide this for you.

FEES FOR SERVICE

Payment for Counseling Services (Individual, Couple, and Family) are due at each session. The fee provided is for an approximately 45 minute session. Extended sessions will incur additional costs.

Additional fees will apply for any services not listed above, to include but not limited to: court appearances, phone calls over 5 minutes, reports or file inquiries. If you have any questions about the cost for these services, please speak with your counselor.

PLEASE SELECT THOSE THAT APPLY

- □ My session will be paid by my **INSURANCE** with a copay of $_____ due at the time of the appointment. **INITIAL** _____

- □ My **EAP** has authorized a total of _____ sessions for counseling at no expense to me. **INITIAL** _____

- □ My fee for my session that are not covered by the above are $_____.
INITIAL_____