Office Use Only

Client No.: _____

Request Monthly Statement? Y ○ N ○

Therapist: _____

Therapist No.: _____

Individual ○ Group ○ Family ○
Marriage ○ Evaluation /Consultation ○

Office of Pastoral Care and Counseling
www.mhtfamilylifecenter.org

CLIENT INTAKE FORM

Today's Date: _____

General Information:

Name: Last _____ First _____ MI _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Responsible Party (if different from above)

Name: Last _____ First _____ MI _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

	Prefered	Leave msg Yes	Leave msg No	
Home Phone: _____	○	○	○	Email Address: _____
Work Phone: _____	○	○	○	SSN: ___ ___ _____
Cell Phone: _____	○	○	○	

DOB: ___/___/___ ○ Male ○ Female

Place of Employment: _____ Job Title: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Racial/ethnic identity:

○ African American/Black ○ American Indian or Alaska Native ○ Asian or Asian Indian ○ White
○ Hispanic or Latino ○ Middle Eastern ○ Pacific Islander or Native Hawaiian

Marital Status:

○ Single ○ Engaged ○ Married/Partnered ○ Separated ○ Divorced ○ Widowed

Spouse/Partner's Name: _____ # of years together: _____

Religious Denomination/Spiritual Preference: _____

Referred By: _____ May we thank the person? ○ Yes ○ No

Please provide advertising site if located us on the internet

Would you like to join our email listing for upcoming groups, workshops and/or seminars? ○ Yes ○ No

(We respect your privacy and you will not receive unsolicited marketing, nor will we share, transfer or sell your information .)

Information provided on this form is confidential

Counseling Concerns

What brings you in today?

_____

_____

_____

_____

What would you like to see happen as a result of counseling or psychotherapy?

_____

_____

_____

_____

Medical & Psychological History

Physician's Name: _____ Physicians #: _____

Date of last physical: _____

List physical illnesses or symptoms

_____

_____

_____

Current Medications Dosage Frequency Prescribing MD

_____

_____

_____

Psychiatrist Name: _____ Psychiatrist #: _____

Have you ever had counseling or psychotherapy in the past? _____

If yes, when? _____ With whom? _____

Have you or any other family member received help for drug or alcohol dependency? _____

If yes, when? _____ Where? _____

Check which of the following you use, and note the amount and frequency of each:

○ Caffeine: _____ ○ Tobacco: _____

○ Coffee ○ Soda ○ Other drinks ○ Pills

○ Alcohol: _____ ○ Marijuana: _____

○ Cocaine, Crack: _____ ○ LSD: _____

○ Inhalants: _____ ○ Other: _____

Have you (or anyone else) been concerned or felt guilty about your use of drug/alcohol? ○ Yes ○ No If yes, who?

Have you ever needed drugs/alcohol to get going in the morning, to function at work or social events, or to cope with withdrawal symptoms? ○ Yes ○ No

Have you ever had a DUI? ○ Yes ○ No If yes, how many? _____ When? _____

Information provided on this form is confidential

Checklist of Concerns

Please check any related concerns.

Thoughts/Feelings/Mood

- ☐ Anger
- ☐ Anxiety
- ☐ Unable to concentrate
- ☐ Confusion
- ☐ Depression
- ☐ Disliking others
- ☐ Emptiness
- ☐ Excessive worry
- ☐ Failure
- ☐ Fatigue
- ☐ Fear
- ☐ Grieving
- ☐ Guilt
- ☐ Homicidal thoughts
- ☐ Intrusive thoughts
- ☐ Judgment problems
- ☐ Memory difficulty
- ☐ Negative thoughts
- ☐ Obsessive thoughts
- ☐ Oversensitivity to criticism
- ☐ Oversensitivity to rejection
- ☐ Panic Attacks
- ☐ Perfectionism
- ☐ Sadness
- ☐ Self-esteem
- ☐ Shyness
- ☐ Spiritual, religious, or moral issues
- ☐ Stress
- ☐ Sudden mood changes
- ☐ Suicidal thoughts
- ☐ Suspicious
- ☐ Temper problems
- ☐ Thoughts of hurting self
- ☐ Thoughts of hurting others
- ☐ Frustrated
- ☐ nervousness

Other Concerns

- ☐ _____
- ☐ _____
- ☐ _____

Work & School

- ☐ Absenteeism
- ☐ Tardiness
- ☐ Difficulty supervision/ co-workers/class-mates
- ☐ Procrastination
- ☐ Career concerns
- ☐ School problems
- ☐ Transition ☐ Performance

Behavior

- ☐ Aggressive, violence
- ☐ Alcohol use
- ☐ Argumentative
- ☐ Avoidant
- ☐ Compulsive behavior
- ☐ Controlling
- ☐ Purging
- ☐ Smoking
- ☐ Withdrawal from others
- ☐ Decreased/lack of sexual interest
- ☐ Dependency
- ☐ Destruction of property
- ☐ Drug use
- ☐ Eating problem
- ☐ Financial problems
- ☐ Self-destruction/self-sabotage
- ☐ Stealing
- ☐ Loss of interest
- ☐ Gambling
- ☐ Hyperactivity
- ☐ Internet problems
- ☐ Irresponsibility
- ☐ Isolation
- ☐ Legal Problems
- ☐ Self-neglect
- ☐ Threats
- ☐ Sleep difficulty
- ☐ Letting others taking advantage of you
- ☐ Lying
- ☐ Not able to relax
- ☐ Pornography
- ☐ Preoccupation with sex
- ☐ Procrastination
- ☐ Sexual dysfunction
- ☐ Weight loss/gain
- ☐ Loss of appetite/overeating

Family & Relationships

- ☐ Affair
- ☐ Childhood issues (yours)
- ☐ Divorce
- ☐ Friendships (unable to maintain)
- ☐ Interpersonal conflicts
- ☐ Parenting
- ☐ Problems with spouse
- ☐ Problems with parents
- ☐ Problems with child(ren)
- ☐ Problems with partner
- ☐ Separation
- ☐ Problems with communication

Abuse

- ☐ Abuse of Alcohol
- ☐ Abuse of Drugs
- ☐ Emotional abuse by another
- ☐ Verbal abuse by another
- ☐ Financial abuse
- ☐ Neglect
- ☐ Physical abuse by another
- ☐ Sexual abuse by another

Y N

- ☐ ☐ Have you ever been hit by your spouse/partner or another? If so, by who? _____ How frequent? _____
- ☐ ☐ Have you ever been pushed by your spouse/partner or another? If so, by who? _____ How frequent?_____
- ☐ ☐ Have you ever been locked in a room by your spouse/partner or another? If so, by who?_____ How frequent?_____
- ☐ ☐ Have you ever been called another name by your spouse/partner or another? If so, by who?_____ How frequent?_____
- ☐ ☐ Have your ever been beaten/threatened by your spouse/partner or another? If so, by who? _____ How frequent?_____
- ☐ ☐ Have finanical resources been held back by your spouse/partner? If so, by who? _____ How frequent? _____
- ☐ ☐ Have you ever been violent (hit, pushed, verbal, sexual, emotional or physical abuse) toward anyone? Who and frequency?

_____

Information provided on this form is confidential

INFORMATION, DISCLOSURE AND CONSENT FORM

Welcome. *The Margie Ree Hansford-Thurmond Family Life Center* (MHT Family Life Center), Office of Pastoral Care and Counseling is excited about welcoming you as a potential client. We believe it is important for you to be informed about the nature of counseling or psychotherapy, the policies and procedures governing the help you will receive here, the fees charged for our services, and your rights as a client. At the end of this statement there is a place for you to sign, signifying your general consent to therapy. Our center is concerned about the whole person – mind, body, and spirit and seek to provide you therapy to address the same.

Pastoral Counseling and Psychotherapy. The words counseling and psychotherapy (referred to below as "therapy") often are used interchangeably to indicate forms of help that address various kinds of personal and family distress such as depression, anxiety, adjustment difficulties at work or with other people, and marital and family conflicts. The goals of therapy range from the relief of symptoms to significant life changes based on acquiring a better understanding of one's personal, interpersonal, and social circumstances.

Pastoral counseling refers to the process by which a pastoral counselor utilizes insights and principles derived from the disciplines of theology and the behavioral sciences in working with individuals, couples, families, groups and social systems toward the achievement of wholeness and health. (American Association of Pastoral Counselors).

Psychotherapy is the "Treatment of emotional, behavioral, personality, and psychiatric disorders based primarily on verbal or nonverbal communication and interventions with the patient, in contrast to treatments using chemical and physical measures." Psychotherapy simply is an aim to reduce psychological distress through talking. (Medilexicon's Medical Dictionary)

Our therapists work within the standards and ethical guidelines of their licensing boards, and professional associations. They also respond to the spiritual and theological needs of clients for whom values, beliefs, and religious affiliations make a difference in the process of changing and growing, and who want these factors to be considered in their therapy.

Therapy Process. Therapy begins with an intake process designed to evaluate your needs and difficulties and to help you and the therapist make a decision about engaging in therapy. This may take one interview or a series of interviews. If you or the therapist believes someone else could better meet your needs, you will be provided a referral to get connected with another counselor. The therapy process itself may take many forms, depending on the issues that need to be addressed and how far you wish to go in dealing with them. Treatment is guided by a treatment plan that you and your therapist both agree to pursue. Therapy ends when the work is done, or at the point you decide to end it.

Therapy Policies and Procedures. Your rights as a client. You have all of the rights established by the state of Georgia governing clinical practices. These include the rights of consent to treatment, of seeking disclosure from your therapist about his or her qualifications, of requesting a different therapist, of ending treatment at any time, of accessing the client grievance procedures, and of having the records of your treatment kept in confidence.

Confidentiality. *What you tell your therapist will be kept strictly confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statutes, or as part of the professional practice of this center.* By law, there are circumstances when the therapist must report information to the appropriate persons or agencies, for example: a) if you threaten grave bodily harm or death to yourself or someone else; b) if you reveal information about child, elder, disabled or dependent adult, or parental abuse; or c) if ordered by a court of law. If your therapy is court ordered, the results of treatment or tests must be revealed to the court. In all other instances, your written permission is required before your therapist or The MHT Family Life Center, Office of Pastoral Care and Counseling can reveal information about your treatment as we maintain high clinical standards in our diagnosis, treatment, case records, business operations, and quality control. The MHT Family Life Center, Office of Pastoral Care and Counseling adheres to standard professional practices. We will protect your confidentiality.

Appointments and Cancellations. ***All appointments are made with your counselor. If you are unable to keep a scheduled appointment, please notify your counselor 24 hours in advance. Failure to do so will result in the standard fee being charged ($135 or $150) as a result of no call/no show for your regular scheduled session.***

Emergency Contact. Your therapist will provide you with a voicemail/contact phone number and will let you know his/her availability in an emergency. In the event of a mental health emergency in which you are not able to contact your therapist, you should call 911 or proceed to the nearest hospital emergency room.

Fees and Payment. *Therapy sessions last 50-55 minutes and our standard fee is $135 (individual, spiritual direction) or $150 (couples/marriage/family) per session.* The fee can be adjusted based on family size and financial circumstances. The fee will be discussed in the first session with the therapist. Qualified sliding fee is $ _____.

Clinical Evaluation Fee: $175 for anger management, employment, denominational, and other court/non-court mandated evaluations and assessments.

All credit card payments will be assessed $5 fee for services under $150 and 5% service fee over $150.

We request payment at the time of your therapy appointment. You may pay by cash, check, healthcare savings account or flexible spending account, credit card or debit card. Each check returned due to insufficient funds will result in The MHT Family Life Center, Office of Pastoral Care and Counseling charge to you $35. If your account is more than 60 days overdue, we reserve the right to turn your account over to a collection agency. You specifically waive any right to confidentiality regarding financial information given by The MHT Family Life Center, Office of Pastoral Care and Counseling to a collection agency.

Ending Therapy. Although you may end therapy at any time, it is preferred that you have at least one face-to-face concluding appointment with your therapist rather than terminating by telephone, mail, or by not showing up. At the time of discharge, you may be given or sent a Client Satisfaction Form that is used to elicit feedback on the therapy process. This is a valuable tool to increase our awareness of the strengths and weaknesses of our services.

General Consent to Therapy

Please initial the following (if applicable):

___ I have seen and read the information contained in this Information, Disclosure and Consent Form

___ I have seen and/or been offered a copy of The MHT Family Life Center, Office of Pastoral Care and Counseling confidentiality policy practices as mandated by the *Health Information Portability & Accountability Act* (HIPAA).

___ I consent to treatment as described in this form.

___ I will pay for my therapy expenses as described above.

___ I hereby authorize the release of healthcare information necessary to process any claims generated by The MHT Family Life Center, Office of Pastoral Care and Counseling.

I acknowledge that I have been notified of the information, disclosure and consent form of The MHT Family Life Center, Office of Pastoral Care and Counseling.

_____ _____

Signature Printed Name Date

_____ _____

Signature Printed Name Date

****

If client is a minor, name of client and signature of parent/guardian:

_____ _____

Client Name Signature of Parent/Guardian Date

_____ _____

Client Name Signature of Parent/Guardian Date

The Margie Ree Hansford-Thurmond Family Life Center
Office of Pastoral Care and Counseling

NOTICE OF PRIVACY PRACTICES

This notice tells you how we make use of your health information at our Center, how we might disclose your health information to others, and how you can get access to the same information. Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have a **legal responsibility** under the laws of the United States and the state of Georgia to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.

This notice takes effect on June 1, 2012 and will be in effect until we replace it. We have the right to change any of these privacy practices as long as those changes are permitted or required by law. Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at *The Margie Ree Hansford Thurmond Family Life Center* (MHT Family Life Center), Office of Pastoral Care and Counseling.

These changes could also affect how we protect the privacy of any of your health information we had before the changes. When we make any of these changes, we will also change this notice and give you a copy of the new notice. When you are finished reading this notice, you may request a copy of it at no charge to you. If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you. If you have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no charge to you.

Here are some examples of how we use and disclose information about your health information. We may use or disclose your health information…

1. To your physician or other healthcare provider who is also treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services we provide for you.
5. To our own staff in connection with our Center's operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
6. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect your health information from that point on.
7. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects of your health information that are necessary to respond to the emergency.
8. *The Margie Ree Hansford-Thurmond Family Life Center* (MHT Family Life Center), Office of Pastoral Care and Counseling expects its staff to follow the laws of the State of Georgia in reporting to the designated authorities intentions on the part of clients to commit suicide, homicide or incidents of child

abuse. **(Georgia Code:19-7-5)** We will not use your health information in any of our Center's marketing, development, public relations, or related activities without your written authorization. We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

As a client of the MHT Family Life Center, Office of Pastoral Care and Counseling **you have these important rights**:

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.
B. You can ask us for photocopies of the information in part "A" above.
C. We will charge you $.25 per page for making these photocopies.
D. You have a right to a copy of this notice at no charge.
E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if your primary language is not spoken at this Center, and we are treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.
F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.
G. You can make a written request that we amend the information in part "A" above.
H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.
I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.
J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center's operations. This can go back as far as six years, but not before January 1, 2008.
K. If you request the accounting in "J" above more than once in a 12 month period we may charge you a fee based on our actual costs of tabulating these disclosures.
L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person:

Compliance Officer: Mary Mitchell
Telephone: (678) 758-7093
Fax: 888-734-8738

Mailing Address: 710 King Road
Riverdale, Georgia 30274

I acknowledge that I have been notified of my privacy rights and of The MHT Family Life Center, Office of Pastoral Care and Counseling privacy policy and procedures.

_____ _____

Signature Printed Name Date

_____ _____

Signature Printed Name Date

****

If client is a minor, name of client and signature of parent/guardian:

_____ _____

Client Name Signature of Parent/Guardian Date

_____ _____

Client Name Signature of Parent/Guardian Date