Jasper Counseling Associates

201 Cove Road
Jasper GA 30143
Phone: (706) 253-9515 Fax: (706)253-9516

M. Kathleen West, LCSW *Ann S. Pike, PhD*

NEW CLIENT REGISTRATION

Welcome to Jasper Counseling Associates! Please read and complete the following pages.

Client's Name: _____ Today's Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone Number(s): Home _____ OK to Call: Y or N Leave Message: Y or N

Cell _____ OK to Call: Y or N Leave Message: Y or N

Work _____ OK to Call: Y or N Leave Message: Y or N

Email Address: _____

Gender: (circle) Male Female SSN: _____ Date of Birth: _____

Marital Status: (*please circle*) Single Married Domestic Partner Separated Divorced Widowed

Employer: _____ Job Position/Title: _____
Employer's address: _____ City: _____ State: ____ Zip: _____
If Student, Name of School: _____ Grade: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? Sign___ Insurance co___ Doctor___ Family/Friend___ Website____ Other_____

****If the Client is a Minor Child, we need the following information****

Name of Parents/Legal Guardian: _____
Address (If Different from Client): _____ City_____ State____Zip:____
Phone Number(s): Home _____ OK to Call: Y or N Leave Message: Y or N
Cell _____ OK to Call: Y or N Leave Message: Y or N
Work _____ OK to Call: Y or N Leave Message: Y or N

Insurance Information (Please provide copy of your insurance card)

Name of Insured: _____ Relationship to Client: Self / Spouse / Parent / Other
Address of Insured: _____ City:_____ State:____ Zip:_____
Insured's Date of Birth _____ Male _____ Female _____
Name of Employer/Group that Insurance is through: _____
Employer's Address: _____ City:_____ State:____ Zip:_____

Primary Ins Name/Address: _____
Ins ID # _____ Group #_____ Phone:_____

Secondary Ins Name/Address: _____
Ins ID # _____ Group #_____ Phone:_____

Medical Information

Patient's Primary Care Physician: _____ Phone # _____

Physician's Address: _____ City _____ State _____ Zip _____

Please list any other current medical or health problems, as well as, the treatment provider(s) working with you:

_____

_____

_____

List any MEDICATIONS that you are currently taking or have taken in the past 6 months, condition being treated, and physician:

	Medication	Mg / Dosage / How Often	Condition Treated	Physician	Taking Now?
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

Other: _____

If you (or your child) are CURRENTLY experiencing any of the following to the point where you/they feel troubled or bothered, CIRCLE the item(s). Please place a CHECKMARK next to any symptoms that you may not be experiencing currently, but which have been significant or problematic in the PAST:

Aggressiveness/Anger	*Drug Abuse*	*Paranoid Feeling*	*Sexual Problems*
Alcohol Abuse/Addictions	*Excess Stress*	*Parent/Child Problem*	*Sleep Problems*
Anxiety/Nervousness	*Hallucinations*	*Poor Concentration*	*Strong Fears*
Confusion	*Homicidal Thoughts*	*Poor Appetite*	*Suicidal Thoughts*
Death of a Loved One	*Hopelessness*	*Poor Memory*	*Very Low Energy*
Depression	*Legal Problems*	*Recent Lifestyle Change*	*Weight Loss*
Disorientation	*Marital/Relationship Problems*	*Restlessness*	*Weight Gain*
Divorce	*Panic Attacks*	*School Problems*	*Work Problems*

Other(s): _____

Psychosocial History

Client Name: _____ Date: _____

What brings you in today? (symptoms and brief history): _____

_____

_____

Who are the members of your family: _____

_____

_____

Highest school grade completed? _____ Degree(s): _____

School Information and status: _____

_____

Are there any current economic or financial stresses? _____

_____

Whom do you socialize with? _____

Leisure Activities: _____

_____

Are there any significant cultural/spiritual influences in your life? _____

_____

Are you having any issues with sexuality or intimacy? (including pregnancy issues) _____

_____

Do you have any medical conditions? _____

Are you currently on ANY medication (including over the counter, vitamins, herbs, etc) _____

_____

Do you have any allergies? _____

Have you ever received counseling or psychotherapy before? Yes _____ No _____
If yes, what did you seek help for? _____

Do you feel like you benefitted from this experience? Yes _____ No _____

Please list name(s) of any previous counselors, therapists or psychiatrists: _____

_____

Dates seen (approximate, if necessary): _____

Has anyone in your household ever received counseling / psychotherapy / inpatient psychiatric hospitalization / substance abuse treatment? Yes _____ No _____ If yes, please explain: _____

_____

_____

If you think alcohol or substance use is, or could be, a concern for yourself OR someone else in your household, please explain who you have concern for, the substance(s) used, and level of use: _____

_____

_____

Do you now have (or have you ever had) a substance abuse problem and/or treatment? _____

_____

Are you experiencing any legal issues? _____

_____

What are your current strengths? _____

_____

Additional comments: _____

_____

_____

Informed Consent to Treatment

I voluntarily consent to the examination, treatment and procedures which may be performed as part of my care or the care of my minor child by **M. Kathleen West, LCSW / Ann S. Pike, Ph.D. (circle one)**, hereinafter referred to as "my therapist". **Initial**_____

I hereby authorize Kathleen West, LCSW / Ann S. Pike, Ph.D. (circle one) to release to any appropriate insurance related entity or collection agency the information needed to process claims for payment in reference to my treatment. **Initial** _____

Signature of Client, Parent or Legal Guardian: _____

Please read and initial in the designated spaces that you have read and understand the material and agree to the conditions set forth herein:

AUTHORIZATION:
I hereby authorize the staff/my therapist to notify the referral source (if he or she is a professional) of my having made this appointment. This alone will be disclosed to the referring professional and is done only as a professional courtesy. **Initial** _____

PURPOSE OF TREATMENT:
I understand that the purpose of treatment is to restore and improve functional behavioral health through therapeutic modalities including, but not limited to, individual and/or family therapy, cognitive behavioral interventions, and encouraging the use of community resources and informal supports. **Initial** _____

TERMINATING TREATMENT:
I am aware that I may stop treatment at any time. I understand that no promises have been made to me as to the results of treatment or recommendations provided by my therapist. **Initial** _____

I understand that by terminating services against the advice of my treatment team, I may not fully benefit from resolution of symptoms for which I sought treatment. **Initial** _____

MY RIGHTS:
I am aware that it is my responsibility to discuss concerns of care with my therapist. If issues remain unresolved and are believed to be an ethical or legal violation of the therapeutic contract, I may file a complaint through my behavioral health insurance company. **Initial** _____

I understand that my therapist may determine that additional or specialized treatment is clinically necessary (such as psychiatric services and/or medication). In the event that my therapist is unable to provide that treatment, my therapist will suggest appropriate referrals or alternatives. I am free to choose my own treatment or decline further treatment services. In addition, I understand that my therapist is not responsible for the cost of any recommended treatment. **Initial** _____

PAYMENT FOR SERVICES:
I understand that payment is due in full at the time of service. Should my account become delinquent and be referred to any third party for collection effort, I agree to pay all reasonable attorney's fees, court costs and a collection expenses. I also understand that my therapist reserves the right to suspend/terminate services until overdue balances are paid. I understand that if any questions should arise concerning the status of my account, I have the responsibility to direct such inquiries to my therapist. **Initial** _____

ASSIGNMENT OF BENEFITS:
I authorize the payment of my insurance benefits directly to my therapist on my behalf. I understand I am responsible for all deductibles, co-insurance and non-covered charges. **Initial** _____

APPPOINTMENTS AND CANCELLATIONS:
I understand that patients are seen on appointment only and that any cancellation of an appointment not given 24 hours in advance of the scheduled time will incur a fee equal to the regular fee rate for my therapist. (Please note most insurances do not reimburse for missed appointments). **Initial** _____

HIPPA RIGHTS:
I understand that my therapeutic sessions are completely protected by federal HIPAA confidentiality laws **with the following exceptions**:

1. If any person treated threatens violence or harm to him/herself and/or to another person, the appropriate authorities will be contacted to insure the safety of all concerned parties.

2. If reason arises during treatment to suspect ongoing child/elder abuse, this will be reported to the appropriate authorities.

3. If a court of law issues a Court Order to release information, the therapist must comply.

4. My therapist may receive consultation or supervision from another professional. If so, your case may be discussed confidentially with this supervising professional.

Information about your case will not be disclosed without your prior written permission, except in the above instances. **Initial** _____

SIGNATURE:
Please sign below and date to indicate you have read and understand the above and agree to those arrangements outlined concerning your treatment. You have the right to request a copy of this document for your records.

Client Signature: _____ Date: _____

Signature of Responsible Party (if different from client): _____

Relation to Client: _____

Witness: _____ Date: _____

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Client Rights and Responsibilities:

As a Client, you have the right:

To Receive Services:

- That respect your privacy and dignity
- That are provided in a prompt, courteous and respectful manner
- That respect your cultural and ethnic identity, religion, disability, gender, age marital status and sexual orientation
- That are provided in a physical environment that is safe, sanitary, allows for effective treatment which safeguards the privacy and confidentiality of interactions between you and your therapist
- From therapists who are qualified, competent, focused on your care, and reasonably accessible to you
- That emphasize your participation in developing a treatment plan specific to your needs and include your agreement to work toward defined goals
- That in relation to intake and treatment are free of discrimination on the basis of age, sex, race, creed, color, national origin, ethnicity, religion, marital status, disability or sexual orientation

To Current Information Concerning:

- How to access emergency services needed outside of normal business hours
- Resources and procedures available for communicating concerns or questions, for expressing dissatisfaction with services or care
- Possible consequences for refusing treatment plan recommendations
- Your responsibilities to ensure better treatment outcomes
- Your records and having information explained or interpreted as a necessary, except when protected or restricted by law

Client Signature: _____ Date: _____

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Telehealth Treatment Consent

Telemental health is a live two-way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding

I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telemental health sessions will be recorded or photographed.

I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.

I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet-based communication is not 100% guarantee to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that I or my therapist may discontinue the telemental sessions at any time, if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/or my emergency contact.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for recontact.

I understand a "no show" or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment.

I understand my therapist will advise me about what telemental health platform to use and he or she will establish a video conference session.

Client Consent

Client Name: _____ (Printed)

_____ I hereby give my informed consent for the use of telemental health in my care

Client Signature: _____