New Beginnings Counseling, LLC
Lisa Sackellares, LCSW
104 Pilgrim Village Drive * Suite 300 * Cumming GA 30040
* Fax: 770-406-8872 * Cell 678-740-3022

PATIENT REGISTRATION FORM

First Name: ______________________Last Name: ___________________________MI: ______ DOB: _____________

Address: ____ Age: _________________
City: ________________________________ State: _________ Zip: ______________ Sex: _________________
Home Phone: _______________________________________ Cell Phone: ____________________________________
Email Address: ____

SSN: _______-______-_______ Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Other: _________

Responsible Party: ____Relationship: ________________________

Occupation: ____ Employer: _________________________________
Employer City: ____Work Phone: _______________________________

Client's Spouse or Parent: _________________________________ Telephone #: ______________________________

Emergency Contact: ______________________________________ Telephone #: _______________________________
Relationship: ____

How were you referred to our office? ____

Preferred Method of contact: _____Text _____Home _____ Cell ______ Work _____ Email

INSURANCE INFORMATION

Company Name: ____ Telephone #: _______________________________
Member ID #: ____ Group #: ___________________________________
Policy Holder: ____ Relationship: ______________________________
Policy Holder's Social Security No. (if different from Client): __________-________-____________
Policy Holder Date of Birth: ___________________

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to New Beginnings Counseling, LLC for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that if I will be charged the insurance allowable rate, or standard fee if private pay, for any missed appointments which are not rescheduled or cancelled within **24** hours of the scheduled appointment time. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collection expenses.

____
Client Name

____ __________________________
Client or Parent/Guardian Signature Date

INFORMED CONSENT

Client Name: ____ DOB: _____________ Date: _____________

X________I understand that I will be receiving an assessment, evaluation, and/or treatment from Lisa Sackellares, LCSW. The type and extent of services that I will receive will be determined following an initial consultation.
X________Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear and anger. Intense feelings of anxiety, depression, loneliness, or helplessness may also be aroused.
X________ I understand that New Beginnings Counseling, LLC does not provide crisis treatment after hours and if I believe I am a danger to myself or others I will contact the Georgia Crisis Hotline at 1-800-715-4225 or call 911.
X________ You should know that your therapist is not a physician and cannot prescribe or provide you with any drugs or medication or perform any medical procedures. If medical treatment is indicated, your therapist can recommend a physician or psychiatrist for you or you can choose a health care professional you wish to see.

CONFIDENTIALITY

X________ Confidentiality and privileged communication remain the right of all clients of counselors according to Georgia State Law. I understand that information concerning treatment or evaluation may be released only with the sole authorization and consent of the person treated or evaluated, or such person's parent/guardian, and with the agreement of the counselor. There are exceptions to the confidentiality of information in the following circumstances (as provided by law): (1) Where there is a clear and imminent danger to the client or others, the counselor may take reasonable personal action or inform the responsible authorities; such as in, suspect of child abuse or suicidal ideation or homicidal ideation will be reported; and (2) if the counselor is required by a court to give information. Except as required by law, you, the client/parent/guardian must sign an authorization to release clinical records to the counselor to talk to or share clinical records or information with anyone, including referred doctors, insurance companies, or family members. All people attending sessions would be required to sign a consent to authorize release of clinical records. Counselors will be discreet if it is necessary to contact you at home or work. In keeping with generally accepted standards of practice, counselor frequently consults with other mental health professionals regarding the management of cases. The purpose of this consultation is to ensure quality care. Every effort is made to protect the identity of clients, including any financial records (including payment via credit/debit card information).
X________ I understand that appointment reminders can be made over email/phone/text and this is not HIPPA compliant. Therapeutic Impressions LLC is not responsible for a breach of information through email account or phone.

ACKNOWLEDGMENT OF DISCLOSURE

X________ The client/parent/guardian has the responsibility and right to (1) choose their therapists and the treatment modality that best suits their needs; (2) discuss with the counselor any concerns about treatment; (3) request a change in approach; (4) request referral to another therapist; and/or (5) discontinue therapy. The counselor can make no guarantees of results. The counselor follows the ethical guidelines set forth by the National Association of Social Workers/Georgia Counselors Association/the Georgia Composite Board of Professional Counselors.
X________ You have the right to obtain a paper copy of this notice from us, upon your request, even if you have agreed to accept this notice electronically. You are also agreeing that you have read the Notice of Privacy and agree with it.

CANCELATION POLICY AND FEES

X________ If you must cancel your appointment, please phone at least 24 hours prior to your scheduled time. Please understand that you are responsible for the time reserved and for notifying me when a change in appointment time is needed. You will be charged the same amount that your insurance company would pay for your appointment. The exception to this policy is in the case of an extreme emergency, at my discretion.

Addendum to Patient Registration Form
Informed Consent

Payment of Fees for Denied and/or Non-Covered Services

I, ______________________________________, understand that some services may not be considered eligible benefits (e.g., services and/or supplies may be determined to not be medically necessary, non-covered or investigational) by my health insurance provider.

I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements and non-covered services.

Examples of these non-covered items include, but are not limited to, multiple visits in one day, court documentation, depositions, report writing, in person or phone conferences and/or meetings and supplies.

Examples of Standard Fees:

Court Appearance (must be paid PRIOR to scheduling) - $1,200.00

Depositions (must be paid PRIOR to scheduling) - $150.00/per hour

Patient Phone Consults (unrelated to scheduling matters) - $50.00/per hour (billed at a minimum of 15 minutes)

Multiple visits in one day - Your contracted insurance allowable rate for same service type
I agree to be financially responsible for any and all related charges if they are not covered by my health insurance.

____
Client or Parent/Guardian Name

____ _____________________
Client or Parent/Guardian Signature Date

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Financial Policy

When you begin services with your therapist you will be placed in one of the following payment account categories:

1) If you choose not to use insurance benefits, or you do not have insurance benefits, you will be placed in a "private pay category." The fee for your sessions will be agreed upon prior to your first session and all payments are due at the time services are rendered.

2) If you would like to use your in-network or out-of-network insurance benefits and you **have met** your deductible, New Beginnings Counseling, LLC will be happy to file your insurance claim. You will be placed in an "insurance pay category." Any co-pays or coinsurance fees will be due at the time services are rendered.

3) If you would like to use in- or out-of-network insurance benefits but you **have not met** your deductible, you will be placed in a "private pay category" and you will be provided a Superbill. A Superbill is a statement used by members to file a claim to their insurance company for credit toward the deductible or for reimbursement of fees paid out of pocket. Please note: The deductible/reimbursement fee typically differs from the private pay fee and you may not be credited or reimbursed the full amount of the private pay fee. Once your deductible has been met you will be moved to an "insurance pay category."

4) If you choose to utilize Employee Assistance Program (EAP) benefits, you will be placed in an "EAP category." Your EAP will be billed for all session fees. It is your responsibility to ensure that your therapist has your EAP company information, authorization number, and how many sessions are authorized. In the event that the EAP refuses payment, you will then be placed in a "private pay or insurance pay category" and you will be responsible for any payments owed to the therapist.

Please Note:

- New Beginnings Counseling requires a 24-hour notice if you cannot make your appointment time. You will be charged the contracted insurance rate as a cancellation/no show fee if you do not provide 24-hour notice.
- If you request that an invoice of your services be sent to you via email, you are agreeing that you understand that email may not be a secure correspondence and you do not hold New Beginnings Counseling, LLC responsible for any breach of information through your email account.
- Copays and other session fees may be paid with money order, cash, check, or credit card. A $25 fee may be charged for any returned checks.

By signing below, you are acknowledging and agreeing to this financial policy.

_______________________________________ ____________________
Client or Parent/Guardian Signature Date

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CLIENT INTAKE INFORMATION

Client Name: ____ DOB: _____________ Date: ____________

Counseling Concerns

Why are you seeking help now? ____
____
____
____

What would you like to see happen as a result of psychotherapy?_______________________________
____
____
____

How would you rate current stress level? None 0 1 2 3 4 5 6 7 8 9 10 Extreme

Medical/Psychological History

Physician's Name/Number: ____

List of physical illnesses/symptoms: Check if none _______
____
____ Date of last physical:
____ __________________
____

Current Medication Dosage Frequency Prescribing Doctor
____
____
____
____

Psychiatrist Name/Number: ____

Have you had counseling before? _______ With whom?_______________________ When? _______________

How would you rate effectiveness of previous counseling? None 0 1 2 3 4 5 6 7 8 9 10 Excellent

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Hospitializations:____
____

Any developmental issues/delays? ____
____

Rate your eating habits: Can't Eat Eating Normally Over Eat _______________________

Rate your sleeping habits: Poor Fair Good Excellent ______________________________

Current steps are you taking towards your physical health: ____________________________
____

Hobbies and activities done for pleasure: ____
____

Check which of the following used and frequency:

Tobacco_____ Coffee______ Drugs_______ Marijuana______

Pills________ Sodas_______ Alcohol_____

<u>Interpersonal Relationships</u>

Name/age of family members living in house: ____
____
____

Closest family member to client: ____

Concerns with family dynamics:____
____

Desired changes within home: ____
____

Please rate your current satisfaction level of home environment: None 0 1 2 3 4 5 6 7 8 9 10 Excellent

Issues with parenting: ____
____
____

Rate your current stress with finances: No stress 0 1 2 3 4 5 6 7 8 9 10 Very stressed

Anything else important to know about you: ____

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CHECKLIST OF CONCERNS

(Please check all that are applicable)

Client Name: ____ DOB: ________________ Date: _______________

Thoughts/Feelings/Mood

□ Anger/frustration/hostility
□ Inattention
□ Depression
□ Excessive worry
□ Fear
□ Grieving (death, divorce, etc.)
□ Hallucinations
□ Intrusive thoughts
□ Judgement problems
□ Memory difficulties
□ Negative thoughts
□ Obsessive thoughts
□ Panic attacks
□ Sadness
□ Self-esteem
□ Shyness
□ Stress
□ Sudden mood changes
□ Suicidal or Homicidal thoughts

Family & Relationships

□ Affair
□ Childhood issues (your childhood)
□ Divorce/Separation
□ Interpersonal conflicts
□ Parenting
□ Relationship
□ Problems/Differences

Work & School

□ Absenteeism
□ Career concerns, goals, choices
□ Difficulty with coworkers/peers
□ Difficulty with supervisors/teachers
□ Performance
□ Tardiness
□ Procrastination
□ School problems

Behavior

□ Abuse
□ Aggression, violence
□ Alcohol use
□ Argumentative
□ Compulsive behavior/rituals
□ Controlling
□ Decreased/lack of sexual interest
□ Destruction of property
□ Eating problems
□ Financial problems, debt
□ Hyperactivity
□ Internet problems
□ Isolation
□ Legal problems
□ Codependency
□ Lying
□ Not able to relax
□ Eating Disorder
□ Self destruction/sabotaging
□ Self-neglect
□ Sexual dysfunction
□ Stealing
□ Weight, gain/loss
□ Withdrawal from others
□ Loss of interest in former pleasures
□ Sleep difficulty

Addiction

□ Abuse of alcohol
□ Abuse of drugs
□ Dependency
□ Drug use—prescription, over-the- counter, street
□ Gambling
□ Pornography
□ Preoccupation with sex

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RELEASE OF INFORMATION

Client Name: ____ Date: _______________________

X________ To be compliant with HIPPA, we must have your written consent to release any of your mental health records to ANYONE. Please list the names and a contact phone number for anyone you give permission to have your records released to if needed.

Name Phone Number Relationship

____
____
____
____
____
____

I have read and understood the prior statements including the confidentiality form, the disclosure information, the informed consent information, the appointment cancellation policy, and the information regarding consent to release records. My signature indicates that I hereby give my consent for counseling services. I authorize New Beginnings Counseling, LLC to render counseling services to the following:

____ ___________________
Client Name Date

____ ___________________
Client or Parent/Guardian Signature Date

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Credit Card Authorization Form

Client Name: ____

Cardholder Name: ____

Billing Address: ____

City, State, and Zip: ____

Cell Phone Number: ____

Email Address: ____

Credit Card Type: _______ Visa _______ Mastercard _______AmEx ________ Discover _______ Flex Card

Credit Card Number: ____ Expiration Date: ______________

Card Identification Number (last 3 digits located on the back of the credit card): ________________________

I, _________________________________, authorize New Beginnings Counseling, LLC to charge to my credit card provided herein any amounts due on my account. I agree to have New Beginnings Counseling, LLC maintain my credit card information on file and automatically charge my credit card when payments are due. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. I agree to inform New Beginnings Counseling, LLC within 15 days of any changes in credit card information, and I agree to pay any fees in the event my credit card is declined.

____ ___________________________________

Cardholder Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicates that you have been given the opportunity to review and retain a copy of the Notice of Privacy Practices on the date indicated below.

If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact Lisa Sackellares at any time.

____
Client Name (Printed)

____
If Client Representative, Name (Printed)

____
If Client Representative, Relationship to Client (Printed)

____
Account Number (Office Use)

____
Client or Representative Signature

____
Date Notice Received

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Social Media Policies

Please be advised I do not accept "friend" or contact requests from current or former patients on any social/professional networking site (Facebook, LinkedIn, Twitter, Instagram, etc.). These sorts of connections may compromise your confidentiality and our respective privacy. These connections also may blur the boundaries of our therapeutic relationship and potentially have unforeseen negative consequences for you as my patient.

Medicaid/Medicaid CMO Missed Appointment Addendum

Attention all Medicaid, Amerigroup, Wellcare and Cenpatico Patients

Please be advised that if you are a Medicaid or Medicaid CMO recipient, and you miss three (3) appointments, your care is subject to termination at the discretion of your provider. It is very important that you show up timely to all appointments scheduled, and to remember to reschedule if necessary.

If you have any questions regarding this standard, please do not hesitate to contact our office at any time.

____
Client Name (Printed)

____
If Client Representative, Name (Printed)

____
If Client Representative, Relationship to Client (Printed)

____
Client or Representative Signature

____
Date Notice Received

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Informed Consent for TeleMental Health Services

Introduction to TeleMental health: TeleMental health involves the use of electronic communications (telephone, written and/or video conference). TeleMental health is a fairly recent way of delivering care and there are some limitations compared with seeing a therapist in person. New Beginnings Counseling, LLC will utilize TeleMental health services on an as needed basis based on discretion of Lisa Sackellares and client.

First Name: ____ DOB: _______________________

PLEASE READ THOROUGHTLY AND INTIAL BESIDE EACH BELOW:

1. _____ (Initial) I understand that TeleMental health services are completely voluntary and that I can choose to not do it.

2. _____ (Initial) I understand that none of the TeleMental health sessions will be recorded or photographed without my written permission.

3. _____ (Initial) I understand that cell phones are not as secure as landlines.

4. _____ (Initial) I understand that the law 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 , which identifies me, will be disclosed to other entities without my consent.

5. _____ (Initial) I understand that TeleMental health is done over a secure communication system that is almost impossible for anyone else to access, but that since it is still a possibility, I accept the very rare risk that this could affect confidentiality.

6. _____ (Initial) My therapist has explained to me how the video conferencing technology and telephone procedures will be used. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

7. _____ (Initial) I understand that my therapist or I can discontinue the TeleMental sessions if it is felt that the video conferencing or telephone connections are not adequate for the situation.

8. _____ (Initial) I understand that if there is an emergency during a TeleMental health session, then my therapist will call emergency services and my emergency contacts.

9. _____ (Initial) I understand that if the video conferencing or telephone connection drops while I am in a session, that I will have a phone line available to contact my therapist.

10. _____ (Initial) I understand that I will create a safety plan with my therapist in case of an emergency.

I understand the information provided above regarding TeleMental health. I have discussed the consent with Lisa Sackellares, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of TeleMental health in my care.

____
Client Name

____ _______________________________
Client or Parent/Guardian Signature Date

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INFORMED CONSENT

Interaction with the legal system:

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record, and I will be responsible for charges in producing that record. If I believe it necessary to subpoena my therapist to testify at a deposition or a hearing, I would be responsible for her expert witness fees in the amount of $1,500 got one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day would be billed at the rate of $375/hour including travel time. I understand that if I subpoena my therapist, she may elect not to speak with my attorney, and subpoena may result in my therapist withdrawing as my counselor.