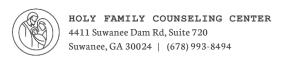


#### INTAKE FORM

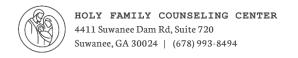
We welcome you to Holy Family Counseling Center, a faith based, independent private practice. It is the goal of your counselor to help you through the difficulties you are experiencing by addressing the whole person and family with dignity. Your counselor will strive to form a collaborative relationship with you in order to assist you in finding healthy solutions to your problems. Although we are independent of the Catholic Archdiocese of Atlanta, Holy Family Counseling Center strives to serve its people by providing evidenced based mental health services that are consistent with Catholic teaching. These pages contain information regarding office policies. Please read them and discuss any questions with your counselor. Your signature where indicated signifies that you have read, understand and agree to abide by these policies.

Please fill out the following forms to help us assess your needs: \_\_\_\_\_\_ Client(s) Name:\_\_\_\_\_ Street Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ You were referred by:\_\_\_\_\_ Preferred phone to contact you: Cell: \_\_\_\_\_\_Home: \_\_\_\_\_Work: \_\_\_\_\_ Email: \_\_\_\_\_ Sex: M / F Would you like to receive information from our email list? Yes or No Marital Status: S/M/D/W Number of Years: \_\_\_\_\_ Is client under age 18? Yes or No If yes, Name of Parent/Legal Guardian bringing child to appointment: IN CASE OF EMERGENCY CONTACT: Name: \_\_\_\_\_\_\_Relationship: \_\_\_\_\_ LIST ALL FAMILY MEMBERS (starting with self): Name School/Place of Employment Relationship to Client \_\_\_\_\_\_\_\_\_\_



### CLIENT CONTRACT AND CONSENT

Client(s) Name:			
Parent or Guardian			
I(We)	voluntarily req	uest counseling/psychotherapy.	
Counseling Fees and Con	sent to Treatment: Counseling fee for	each counseling session is \$125.00.	
discussed with your counselo			nily income below. This will be
<del>-</del>	come (including child support, trust		O \$150,000
\$25,000 or less			Over \$150,000
\$25,000 to \$40,000 \$40,000 to \$55,000			
CONTRACT TERMS AN	D CONDITIONS (please initial each	)	
\$ I underst	eling fee of \$125.00 per each 50 minute s and that in order to qualify for a discour ntation which may include a copy of my l be reevaluated every 6 months or as the o	nted counseling fee, I will need to provide atest tax return and/or pay stub. I under	e my counselor with the restand that any discounted
the counseling fee a2b. I understand that missing an appo	yment is due at time of service. If you agreed upon will apply and be charged.  if my counseling fees are being paid intment, I am responsible for paymentment. If I do not pay the counselies.	d for by a third party and if I fail to ent of the counseling fee to Holy Fa	o give 24 hours notice before mily Counseling Center for
	ll be a \$25.00 returned check fee.		
	ll receive a form that normally suffices f	or insurance reimbursement.	
5. I have read The Privacy Policy and Informed Consent which follows.			
6. IN CASE OF EME	RGENCY, please go to your nearest Eme	rgency Room or call 911.	
there will be a special the therapeutic rela 8. I understand that all i	ly Family Counseling Center services do a rate assessed for this service. <b>Please be a ationship.</b> Information disclosed within session(s) is without my written permission. The only	aware that court involvement can h confidential and may not be revealed to	ave a deleterious effect on anyone outside Holy Family
· —	-		
By signing this form you	are affirming that you have read, u	nderstand, and agree to its contents	s.
(Signatur	e of Client(s) and parent or guardian)	•	<b>/</b> Date)



#### PRIVACY OF INFORMATION POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

**Our Legal Duties:** State and Federal law require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before the policy changes were made. Any changes in this notice will be made available upon request before changes take place. The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

**Duty to Warn and Protect:** When a client discloses intentions or a plan to harm another person or persons, the mental health professional is required to warn the intended victim(s) and report this information to legal authorities. In cases which the client discloses or implies a plan for suicide, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Public Safety:** Health records may be released for judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, military, and when complying with worker's compensation laws.

**Abuse:** If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or crime, and your safety appears to be at risk, we may be required to share this information with law enforcement officials to help prevent future occurrences and to help apprehend the perpetrator.

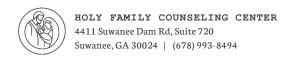
**Prenatal Exposure to Controlled Substances**: Mental health professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**Professional Misconduct:** Professional misconduct by a mental health professional must be reported by other mental health professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the mental health professional's actions, related records may be released in order to substantiate disciplinary concerns.

**Judicial or Administrative Proceedings:** Mental health professionals are required to release records of clients when a court order has been placed. There must be consent for our counselors to disclose information which the couple or family deemed therapeutic or necessary for treatment of the individual, couple, or family. Holy Family Counseling Center services do not include court case appearances. If we are subpoenaed for any reason, there will be a special rate assessed for this service. **Please be aware that court involvement can have a deleterious effect on the therapeutic relationship.** 

n.	:	cf:	1			:444-
b١	v signing this form	vou are affirming that vo	u nave read	. unaerstana	, and agree to	) its contents.

Client	Signature/Date:	



Name\_\_\_

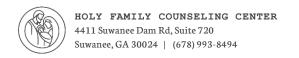
### INFORMED CONSENT FOR COUNSELING SERVICES

\_\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_

Services and Staff: I understand that Holy Family Counseling Center is a professional agency offering a wide range of counseling services, and that these counseling services are provided by licensed psychotherapists, master level therapists/counselors, certified addiction counselors, and graduate level interns. In all cases, trainees are supervised by licensed mental health professionals. Unless you have otherwise lesignated, all cases are discussed within a team supervision setting in order to enhance and assure your quality of care. In addition to providing direct counseling services, Holy Family Counseling Center provides training and consultation.			
<ul> <li>Confidentiality: I understand that all information disclosed within session(s) is confidential and may not be revealed to anyone outside Holy Family Counseling Center without my written permission. The only exception is in situations where disclosure is required by law: <ol> <li>If I present an imminent threat of harm to myself or to others.</li> <li>When there is an indication of abuse of a child or vulnerable adult.</li> <li>If I become gravely disabled.</li> <li>By court order or subpoena.</li> </ol> </li> </ul>			
<b>Electronic Mail:</b> With respect to electronic mail (e-mail), I understand that e-mail is not a confidential means of communication. Furthermore, Holy Family Counseling Center cannot ensure that e-mail messages will be received or responded to if my counselor is not available. I understand that e-mail is not the appropriate way to communicate confidential, urgent, or emergency information, or to schedule/modify/cancel appointments unless you have arranged this with your counselor.			
<b>Emergency:</b> Go to the nearest Emergency Room or call 911.			
Session Recording: I understand that my interviews may be video or audio recorded for the purpose of continued staff training and clinical supervision. The recordings are treated confidentially and are erased after they are used. Any concerns I have about session recording will be addressed by my counselor. I will never be video or audio recorded without my permission or knowledge.			
<b>Risk and Benefits:</b> I understand that there is a possibility of risks and benefits which may occur in counseling. Counseling may involve the risk of remembering unpleasant events and may arouse strong emotional feelings. Counseling can impact relationships with significant others. The benefits from counseling may be an improved ability to relate with others; a clearer understanding of self, values, and goals; increased academic productivity; and an improved ability to deal with everyday stress. Taking personal responsibility for working through these issues increases the likelihood of greater growth.			
<b>Eligibility, Appropriateness, Referrals:</b> The delivery of services from Holy Family Counseling Center to me shall be contingent upon whether the counselor and I can agree that the services are appropriate given the needs and conditions I present. If it is decided that Holy Family Counseling Center is not the appropriate agency to meet my needs, I understand that I will be given referrals to resources more appropriate to my needs and goals.			
I HAVE HAD THE OPPORTUNITY TO DISCUSS ANY QUESTIONS I HAVE ABOUT THIS INFORMATION.			
Client's Signature:			
I HAVE DISCUSSED THIS INFORMATION WITH THE CLIENT.			
Staff Signature:			

# INITIAL ASSESSMENT (Please print) (Page 1 of 2)

Date:/ Clien	t:			
Each client must comple	te a separate assessment.	For example, husband, wife, a	nd child each fill out a separate form.	
1. Do you have any chronic medical conditions or serious illness?YesNo. If yes, please describe.				
2. Are you taking any me	edications?Yes	No. If yes, which ones?		
For how long and for what re	eason?			
Any allergies or drug sensiti	vities?			
3. Do you have military o	experience?Yes	No. If yes, please describe:		
4. Are you experiencing	a great deal of emotional	stress or problems in your	life?	
Yes, a lotMo	ore than usual	Occasionally	Rarely	
5. Do you have relationsl	nip problems with (check	all that apply):		
_				
Spouse/significant othe	rRemarried f	tamily memberslmn	nediate FamilyFamily of Origin	
Extended Family (In-La	ws)People at wo	rkSpec	rific friendsOther	
Check items that apply t	o your situation. Use C fo	or current and P for past.		
headaches	financial problems	feel like crying	hard time with friendships	
dizziness	use of pornography	panicky feelings	feel apart from people	
tremors or tics	sexual compulsions	frightened, scared	loss of interest in things	
difficulty concentrating	sexual problems	people are out get me	can't make decisions	
stomach trouble	drinking problems	unusual thoughts	put up a good front	
bowel trouble	drug problems	anger/temper problems	lonely	
eating problems	compulsive spending	ready to explode	low self esteem	
appetite change	legal problems	irritable	unable to have a good time	
weight loss or gain	feel tense, uptight	feel I will lose control	depressed/down	
sleep problems	unable to relax	angry a lot	feel worthless	
	anxiety /worries	temper problems	suicidal thoughts	
nightmares	always worried	hyper/too much energy	suicidal actions	
family conflicts	feel loss of control	misunderstood		



# INITIAL ASSESSMENT (Please print) (Page 2 of 2)

6. How is your spiritual life right now?	
In good shapeDeveloping _	Needs a lot of workVery poor
7. How many changes would you like to mak	ke in your life?
_Very manySeveral	_A few _None
8. <b>Have you ever spoken with anyone</b> (psycho	ologist, counselor, psychiatrist, etc.) about any of your personal problems?
(If yes, who and when?)	
9. Please describe any past hospitalizations i	n a mental health facility.
10. Please list the things/problems or events	that are creating the most stress in your life at the present time as well as
significant losses and changes in your life.	
1	5
2	6
3	7
4	8
Goals in Counseling – Please list up to three	goals you hope to achieve in counseling. Please be as specific as possible
1	
2	
3	
11. How strongly would you like to talk to a	counselor here about any of your concerns?
very muchmuch	a littlenot really
12. Please state any other concerns, questions	s, or comments:

### REQUEST FOR RELEASE/EXCHANGE OF CLIENT INFORMATION

I (We) I	HEREBY AUTHORIZE		
(Client Name) (Requesting Therapist Name) to release/exchange information contained in my client records to the following individual(s) and/or organization			
(Name and phone nur	nber of person to be contacted)		
The type of information to be released might include record	ls or information concerning attendance,	treatment plan, clinical assessment,	
psychological history, goals and progress, prognosis, or other	er information pertinent to the successful	treatment of said client. The purpose fo	
such disclosure/exchange might include continuity of treat	ment, family involvement, community so	upport, aftercare planning, consultation	
with other staff therapists or referral.			
I hereby release(Requesting Therapist Name) which might arise from the release of the information authorized means such as FAX and/or e-mail. Portions of the information	orized above. I understand that informat	ion may be transmitted by electronic	
understand that I may revoke this consent at any time or that	at it expires automatically as described be	low.	
Date, Event, or Condition of expiration:  I further acknowledge that the information to be released w			
(Signature of Client)	(Signature of Witness)		
(Parent, Guardian, or Authorized Representative)	(Relationship to Client)	/(Date)	



## REQUEST FOR RELEASE/EXCHANGE OF CLIENT INFORMATION WHEN SESSIONS ARE PAID FOR BY A THIRD PARTY

I (We) H	EREBY AUTHORIZE		
(Client Name)	(Re	equesting Counselor Name)	
to release/exchange information contained in my client records to the following individual(s) and/or organization			
(Name and phone numb	per of person to be contacted)		
The type of information to be released might include records	or information concerning attendance,	treatment plan, clinical assessment,	
psychological history, goals and progress, prognosis, or other	information pertinent to the successful	treatment of said client. The purpose for	
such disclosure/exchange might include continuity of treatm	ent, family involvement, community su	apport, aftercare planning, and/or	
consultation with other staff therapists or referral.			
Please initial below next to the information Holy Family Cou	nseling Center can share with the Third	Party Provider referenced above in this	
document.			
Holy Family Counseling Center may send a bill to the	ne provider referenced above which indi	cates information required	
by insurance companies to include the date of the se	ssion, the diagnostic code, the type of th	nerapy and which therapist	
from Holy Family Counseling Center that I am seein	ng.		
Holy Family Counseling Center may give a brief upo	date to the Third Party Provider referen	ced above on my progress.	
I hereby release(Requesting Counselor's Name)	from any and all liabilities, responsibil	lities, damages and claims	
which might arise from the release of the information author	ized above. I understand that informat	ion may be transmitted by electronic	
means such as FAX, email and/or U.S. postal service. Portions	of the information provided may not p	ertain exclusively to my current	
diagnosis. I also understand that I may revoke this consent at	any time or that it expires automatically	y as described below.	
Date, Event, or Condition of expiration:			
I further acknowledge that the information to be released was	fully explained to me and this consent	is given of my own free will.	
(Signature of Client)	(Signature of Wit	ness)	
(Parent, Guardian, or Authorized Representative)	(Relationship to Client)	(Date)	