HOLY FAMILY COUNSELING CENTER
4411 Suwanee Dam Rd, Suite 720
Suwanee, GA 30024 | (678) 993-8494

PETER ATTRIDGE
MS, DOCTORAL STUDENT

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:

Date:_____ Client(s) Name:_____

Street Address: _____

City:_____ 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: _____Phone: _____Relationship: _____

LIST ALL FAMILY MEMBERS *(starting with self):*

Name	DOB	School/Place of Employment	Relationship to Client
_____	____/____/_____	_____	_____
_____	____/____/_____	_____	_____
_____	____/____/_____	_____	_____
_____	____/____/_____	_____	_____
_____	____/____/_____	_____	_____

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CLIENT CONTRACT AND CONSENT

Client(s) Name: _____

Parent or Guardian_____

I(We) _____voluntarily request counseling/psychotherapy.

Counseling Fees and Consent to Treatment: Counseling fee for each counseling session is $125.00.

If you wish to be considered for a discounted fee based on financial need, please indicate your gross annual family income below. This will be discussed with your counselor at your first session.

Gross Annual Family Income (including child support, trusts, inheritance, disability, etc.)

$25,000 or less	_____	$55,000 to $70,000	_____	$100,000 to $115,000	_____	Over $150,000	_____
$25,000 to $40,000	_____	$70,000 to $85,000	_____	$115,000 to $130,000	_____		
$40,000 to $55,000	_____	$85,000 to $100,000	_____	$130,000 to $150,000	_____		

CONTRACT TERMS AND CONDITIONS (please initial each)

____ 1. I agree to pay a counseling fee of $125.00 per each 50 minute session. If I qualify for a discount, the counseling fee will then be $_____. I understand that in order to qualify for a discounted counseling fee, I will need to provide my counselor with the requested documentation which may include a copy of my latest tax return and/or pay stub. I understand that any discounted counseling fee will be reevaluated every 6 months or as the conditions of my income change and that this discounted counseling fee may also change.

____ 2. I understand that **payment is due at time of service.** If you are unable to keep an appointment, **kindly give 24 hours notice**, or the counseling fee agreed upon will apply and be charged.

____ 2b. **I understand that if my counseling fees are being paid for by a third party and if I fail to give 24 hours notice before missing an appointment, I am responsible for payment of the counseling fee to Holy Family Counseling Center for the missed appointment. If I do not pay the counseling fee for the missed appointment, the third party will be notified accordingly.**

____ 3. I understand there will be a $25.00 returned check fee.

____ 4. I understand that I will receive a form that normally suffices for insurance reimbursement.

____ 5. I have read The Privacy Policy and Informed Consent which follows.

____ 6. **IN CASE OF EMERGENCY**, please go to your nearest Emergency Room or call 911.

____ 7. I understand that 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.**

____ 8. 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:

a) If I present an imminent threat of harm to myself or to others.
b) When there is an indication of abuse of a child or vulnerable adult.
c) If I become gravely disabled.
d) By court order or subpoena.

By signing this form you are affirming that you have read, understand, and agree to its contents.

_____ _____/_____/_____

(Signature of Client(s) and parent or guardian) (Date)

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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.

Use of Information: Information about you may be used by Holy Family Counseling Center personnel for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care professionals who provide you with treatment, such as doctors, nurses, mental health professionals, mental health interns, and mental health professionals or business associates of Holy Family Counseling Center such as billing, quality enhancement, training, audits, and accreditation providers. Both verbal information and written records about a client cannot be shared outside Holy Family Counseling Center without the written consent of the client or the client's legal guardian or personal representative. There are certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements. _____***Initial***

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.**

By signing this form you are affirming that you have read, understand, and agree to its contents.

Client Signature/Date: _____

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INFORMED CONSENT FOR COUNSELING SERVICES

Name_____ 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 designated, 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.

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:

1. If I present an imminent threat of harm to myself or to others.
2. When there is an indication of abuse of a child or vulnerable adult.
3. If I become gravely disabled.
4. By court order or subpoena.

Electronic Mail: 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.

Emergency: 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.
_____***Initial to grant permission for session recording***

Risk and Benefits: 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.

Eligibility, Appropriateness, Referrals: 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: _____ Date_____/_____/_____

I HAVE DISCUSSED THIS INFORMATION WITH THE CLIENT.

Staff Signature: _____ Date_____/_____/_____

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INITIAL ASSESSMENT (Please print)

(Page 1 of 2)

Date:____/____/_____ **Client:**_____

Each client must complete a separate assessment. For example, husband, wife, and child each fill out a separate form.

1. **Do you have any chronic medical conditions or serious illness?** ___ Yes ___ No. If yes, please describe.

_____

2. **Are you taking any medications?** _____ Yes _____No. If yes, which ones? _____

_____

For how long and for what reason? _____

Any allergies or drug sensitivities? _____

3. **Do you have military experience**?_____Yes _____ No. If yes, please describe:_____

_____

4. **Are you experiencing a great deal of emotional stress or problems in your life?**

_____Yes, a lot _____More than usual _____Occasionally _____Rarely

5. **Do you have relationship problems with (check all that apply):**

____Spouse/significant other _____Remarried family members ____Immediate Family ____Family of Origin

____Extended Family (In-Laws) ____People at work ____Specific friends ____Other _____

Check items that apply to your situation. Use C for 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
___always tired or fatigued	___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)

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6. **How is your spiritual life right now**?

___In good shape ___Developing ___Needs a lot of work ___Very poor

7. **How many changes would you like to make in your life?**

__Very many __Several __A few __None

8. **Have you ever spoken with anyone** (psychologist, counselor, psychiatrist, etc.) **about any of your personal problems?**

(If yes, who and when?) _____

_____

9. **Please describe any past hospitalizations in 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 much ____much ___a little ___not really

12. Please state any other concerns, questions, or comments:

_____

_____

_____

_____

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REQUEST FOR RELEASE/EXCHANGE OF CLIENT INFORMATION

I (We)_____ **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 number 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 treatment, family involvement, community support, aftercare planning, consultation with other staff therapists or referral.

I hereby release _____ from any and all liabilities, responsibilities, damages and claims
(*Requesting Therapist Name*)
which might arise from the release of the information authorized above. I understand that information may be transmitted by electronic means such as FAX and/or e-mail. Portions of the information provided may not pertain exclusively to my current diagnosis. I also understand that I may revoke this consent at any time or that it expires automatically 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 Witness*)

_____ _____ ____/____/_____
(*Parent, Guardian, or Authorized Representative*) (*Relationship to Client*) (*Date*)

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

I (We)_____ **HEREBY AUTHORIZE** _____
(*Client Name*) (*Requesting Counselor Name*)

to release/exchange information contained in my client records to the following individual(s) and/or organization

_____.
(*Name and phone number 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 treatment, family involvement, community support, aftercare planning, and/or consultation with other staff therapists or referral.

Please initial below next to the information Holy Family Counseling Center can share with the Third Party Provider referenced above in this document.

_____ Holy Family Counseling Center may send a bill to the provider referenced above which indicates information required by insurance companies to include the date of the session, the diagnostic code, the type of therapy and which therapist from Holy Family Counseling Center that I am seeing.

_____ Holy Family Counseling Center may give a brief update to the Third Party Provider referenced above on my progress.

I hereby release _____ from any and all liabilities, responsibilities, damages and claims
(*Requesting Counselor's Name*)
which might arise from the release of the information authorized above. I understand that information may be transmitted by electronic means such as FAX, email and/or U.S. postal service. Portions of the information provided may not pertain exclusively to my current diagnosis. I also understand that I may revoke this consent at any time or that it expires automatically 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 Witness*)

_____ _____ _____
(*Parent, Guardian, or Authorized Representative*) (*Relationship to Client*) (*Date*)