CLIENT INFORMATION

Client Name: _____ Today's Date: _____

Parent / Guardian / Responsible Party (if different from above): _____

Street Address: _____

Mailing Address (if different from above): _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Social Security Number: _____ Date of Birth: _____ / _____ / _____

Sex: ( ) M ( ) F County of Residence: _____

Marital Status: ( ) Married ( ) Divorced ( ) Single ( ) Separated ( ) Widowed

Employment Status: ( ) Employed ( ) Student ( ) Unemployed Occupation: _____

Where Employed / Attending School: _____

Highest Level of Education Completed: _____

RESPONSIBLE PARTY (other than insurance company) if different from client

Name: _____ SS#: ___ - ___ - ___ Date of Birth: ___/___/___

Address: _____ City: _____ State/Zip: _____

Home Phone #: _____ Work Phone #: _____

May we call you at home: ( ) Yes ( ) No May we leave a message on your answering machine: ( ) Yes ( ) No

I understand that if I do not give permission to receive calls and/or messages, I will not be able to be informed of changed or cancelled appointments: ( ) Yes ( ) No

May we contact you by mail: ( ) Yes ( ) No

Emergency Contact: _____ Relationship: _____

Telephone Number(s): _____

How did you hear about Solutions For Growth?: _____ Relationship: _____

CLIENT HISTORY / BACKGROUND INFORMATION

Please answer the following questions so that we may serve you more effectively. If a question does not apply to you, please indicate "N/A".

Why are you seeking help today? _____

_____

_____

_____

Previous Treatment / Counseling – Who with and when? _____

What did the previous provider do with you? _____

How did that work for you? _____

Who is your support system? _____

Legal History: _____

Medical History / Current Symptoms: _____

Primary Care Physician and other treating doctors:

Name: Address: Phone:

_____

_____

_____

Will you give us permission to contact your primary care physician to coordinate your care? (Your insurance carrier may require this): _____YES (Please sign Release of Information) _____NO

Current medications you take, including over the counter medication dosage and date of initial fill and refills:

_____

_____

_____

For Children and Adolescents: Significant birth history: _____

Developmental age walked: __ talked: _____ other: _____

Do you currently have thoughts of harming yourself or someone else? _____ Yes _____ No

Have you had those thoughts in the past? _____ Yes _____ No

INSURANCE INFORMATION AND AUTHORIZATION

******** Complete this Section ONLY if We Are to File Your Insurance ****** ******

If accident related: Date of Accident: ___/__/_ Employment ( ) Auto ( )

PRIMARY INSURANCE: _____ Insured' s SS#: _____

Insurance Co. Address: _____

Insurance Co. Phone Number (Provider Relations): _____ Insured's Birth Date: _____

Insured's Name: _____ Insured's ID#: _____

Coverage Code: _____ Group Code: _____

Insured's Employer: _____ Employer Phone: _____

Employer's Address: _____

SECONDARY INSURANCE: _____ Insured' s SS#: _____

Insurance Co. Address: _____

Insurance Co. Phone Number (Provider Relations): _____ Insured's Birth Date: _____

Insured's Name: _____ Insured's ID#: _____

Coverage Code: _____ Group Code: _____

Insured's Employer: _____ Employer Phone: _____

Employer's Address: _____

I, the undersigned, hereby agree that I will guarantee payment of bills for services rendered by Solutions For Growth, Inc. I hereby authorize payment directly to same of the benefits otherwise payable to me but not to exceed the therapist's regular charges for service. I understand I am financially responsible to the therapist for charges not covered by this agreement. I also understand that, should collections process become necessary, I am responsible for all expenses connected with their process. I further authorize the release of information for insurance purposes.

Signed: _____ Date: _____

Witness: _____ Date: _____

(A photocopy of this agreement shall be considered as valid as the original)

INFORMED CONSENT

I understand that my therapist will discuss therapy options with me, and work with me in formulating my treatment plan. I understand that my therapist will encourage me to choose the treatment method that research has proven to be most effective, unless there are extenuating circumstances that dictate otherwise.

In addition to the client's rights and therapist's expectations, I understand that information provided to my therapist is confidential unless I authorize release of such information with a signed consent form.

I understand that my therapist is legally mandated to report the following situations to the proper authorities should they be disclosed in the course of therapy and that should these be disclosed mandated reporting supercedes confidentiality:

- Client stated he/she is physically or sexually abusing a child or the elderly;
- client is homicidal/suicidal;
- in case of a medical emergency;
- client, if under age, reports they have been or are being physically or sexually abused;
- if the therapist is ordered by the court to testify or produce their records;
- if the client engages in physical assaults on center staff, other clients or property of center.

Federal and State of Georgia laws assure that everything a patient/client tells their mental health professional is to remain confidential and is considered privileged communication. Any information a mental health professional has regarding the patient can only be released with the signed, written consent of the patient (or patient's parent or legal guardian in the case of a child). Thus, confidentiality and privileged communication are your rights, guaranteed under State and Federal laws.

There are, however, two exceptions in which the mental health professional's social responsibility is given precedence over these rights. If a patient intends to harm himself or herself, or another individual, the mental health professional has the responsibility and duty to protect the patient, or warn the person to whom harm is intended. Such action by the mental health professional may require that confidentiality be broken. Of course, breaching confidentiality would be the last resort, occurring only after all reasonable efforts to resolve the situation had failed, and would be limited to the necessary information required to ensure safety.

State of Georgia law also requires that mental health professionals report all incidents of any type of suspected child abuse to appropriate agencies.

I have read the above and understand my rights and the mental health professional's social responsibility.

_____ _____

Client Signature Date

CLIENT RIGHTS AND THERAPIST EXPECTATIONS

CLIENT RIGHTS:

- The right to receive high quality professional services.
- The right to request type of treatment, such as group or individual, in consultation with therapist.
- The right to determine goals of treatment with your therapist
- The right to discuss length of treatment with your therapist
- The right to request a referral to a different therapist.
- The right to refuse a medical consult if not life threatening or dangerous to others.
- The right to terminate therapy.
- The right to determine disclosure of confidential information if not life threatening or dangerous to others.
- The right to discuss any concerns about services with your therapist
- The right to ask about other agency or community resources that may be of help.

THERAPIST EXPECTATIONS:

- The client to maintain agreed upon therapy schedule and keep therapy appointments.
- The client to fully disclose their financial ability to pay in order to set fair fees for service.
- The client to pay for sessions according to agreed upon charges.
- The client to participate in their treatment plan and the formulation of goals.
- The client to respect the confidentiality of other clients.

Signature: Date:

INSPECTION OF RECORDS

All information revealed to your therapist is kept strictly confidential, except in cases involving life-threatening emergencies. No information will be given to other agencies without your written consent unless it is felt that your life or that of another is endangered (see informed consent).

If you, at any time, feel the need to ready your record, you must request permission in writing. The therapist will then review the record, or parts of the record that pertain to you (in cases of couples, families, and groups). If you are under 18 years of age, your parent or guardian must submit the written request and the above procedure will be followed.

If you have corrections you want to make, you must submit them in writing. You will then meet with your therapist to review these changes.

Signature: _____ Date: _____

CONFIDENTIAL TREATMENT CONSENT FORM

Name: _____ Social Security Number: _____

Explanation of Consent Form: This treatment consent form covers all procedures that are not of a nature to require a special consent, and it provides protection for the procedures performed by the professional staff of **Solutions For Growth, Inc.** This form documents that the client has consented to treatment at **Solutions For Growth, Inc**. including but not limited to counseling and therapeutic services. This allows the professional staff at **Solutions For Growth, Inc**. to provide services to you.

This form provides evidence that no guarantee is made by a professional at **Solutions For Growth, Inc**. concerning the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the staff at **Solutions For Growth, Inc**. If you have any questions concerning this or any other matters, it is your responsibility to ask your therapist. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment: I _____, for _____
(Print your name) (Print the client's name)

do hereby voluntarily consent to care and treatment by **Solutions For Growth, Inc.**

I am aware that the practice of counseling is not an exact science and I acknowledge that no guarantees have been made as to the result of treatment. I am aware that I am an active participant in the counseling process and that I share the responsibility for treatment My responsibilities in treatment include informing the therapist of any information that may be relevant to the problems or conditions begin treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability and ending treatment in a responsible way.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

This form has been fully explained to me and I certify that I understand its contents.

I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

_____ _____
(Sign your name) (Date)

_____ _____
(Witness) (Date)

FINANCIAL POLICY

Charges for counseling services are DUE and PAYABLE at the time services are rendered. We want to be sensitive to any financial hardships that you may be have, and will be happy to discuss alternate methods of payment. Please bring this to our attention before your appointment, and we will be happy to work with you in any way possible. Charges may be paid by Cash, Check, MasterCard, or Visa. You will be charged a $25.00 fee for any item returned for insufficient funds.

It is our hope that you will understand that our collection policy is a necessary part in assuring the financial resources required to maintain this health care service for our clients.

INSURANCE CLAIMS AND PAYMENTS

Your insurance is a contract between you, the insurance company, and/or your employer. Payment for our services is ultimately your responsibility. Therefore, it is important that you verify provider participation and benefits with your insurance company prior to your visit.

If we have a contract with your insurance carrier, we will bill the carrier for all services rendered. You are, however, expected to pay all deductibles and co-payments when services are rendered. Please inform us if you have any secondary health insurance which may be responsible to cover the cost of services provided to you. If payment or denial of payment is not received in our office from your insurance within 45 days of claim submission, the total amount will become your responsibility.

Your **DEDUCTABLE** is the amount of money that you must pay for health care expenses before your insurance covers the costs. Often, insurance plans are based on yearly deductable amounts, which you have determined with your insurance carrier. Your **COPAYMENT** is a predetermined (flat) fee that you pay for health care services, in addition to what your insurance covers. The **EXPLANATION OF BENEFITS** or **EOB** is your insurance company's written explanation to a claim, showing what they paid and what you, the client, must pay.

If we have no contract with your insurance carrier, we do not file claims for office services. You will be provided with a copy of your bills so that you may submit it to your insurance carrier for direct reimbursement to you. In the event that a collections process should be necessary, you would be billed for all collection agency/court costs incurred from the process.

Note: In cases of divorce and/or separation, the parent who originally brought the child in for services is responsible for paying this office, regardless of which parent is legally responsible for insurance coverage and medical bills, as established by a divorce or any other agreement. Assignment from the non-custodial parent's insurance carrier will be accepted only after this office has his/her signature on file.

MISSED APPOINTMENTS AND CANCELLATIONS

If you will be unable to keep a scheduled appointment, please give us at least 24 hours notice so that we can give that appointment to another patient who needs to be seen.

Failure to give at least 24 hours notice of a missed or cancelled appointment will result in a $25.00 missed appointment fee.

Please be aware that your insurance company will not pay for any missed appointment fees.

If you have two consecutive missed appointments without 24 hours notification, we will be happy to refer you to another mental health provider.

I have read, understand and agree to the above Financial Policy. I agree to pay for services under the conditions set forth in this billing policy and acknowledge that I am responsible for payment of all services provided, regardless of insurance coverage.

_____ _____

Signature Date

(For additional information regarding common health insurance terms and practices, please refer to your policy or information sites such as www.healthinsurance.org)

SOLUTIONS FOR GROWTH, INC.
P.O. BOX 1693
DAHLONEGA, GA 30533
PHONE: 770-354-2970
FAX: 706-413-3799

Notice of Privacy Practices Receipt and Acknowledgment of Notice

Patient/Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Solutions for Growth's Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Collin J. Vander Pol, LCSW, at 770-354-2970.

_____

Signature of Patient / Client Date

_____

Signature of Parent / Guardian or Personal Representative Date

_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (Power of Attorney, Healthcare Surrogate, Etc.)

□ Patient / Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW THIS NOTICE CAREFULLY.

- Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices, We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection".

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to. quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of you PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect of Children Under the Age of Eighteen
Abuse and neglect of Adults with Developmental Disabilities
Abuse and Neglect of Senior Citizens
Judicial and Administrative Proceedings
Deceased Persom
Emergencies