

Center Point

Adult Intake Form

The following form will become part of your confidential record. Please answer each question as completely and as carefully as you can.

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Street Address: _____ City & State: _____ Zip: _____

May we contact you and/or leave messages via...

Cell Phone? Cell #: _____ Text messaging? Home Phone?: Home # _____

Email?: _____

Employment Background Are you currently employed? Yes No

Employer's Name: _____

Type of Work / Position: _____ Length of time: _____

Personal Information

Describe any physical problems you have that require medication or physical care: _____

How long ago was your last physical? _____

Are you currently receiving medical treatment? Yes No

If yes, please explain: _____

Are you currently taking any prescription medications? Yes No

If yes, please list (or attach a list of medications to this form): _____

Any family psychiatric history (e.g., depression, anxiety, substance abuse)? Yes No

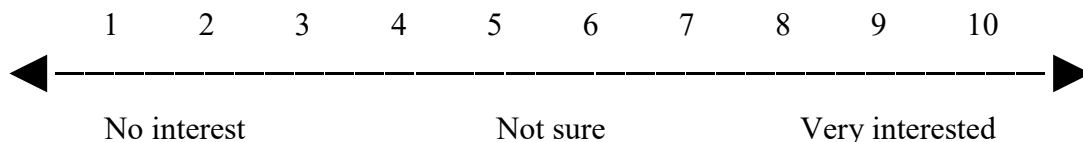
If yes, please explain: _____

How often do you consume non-prescription drugs and/or alcohol? _____ If appropriate: What is your highest use of any substance within the past 6 months? _____

SPIRITUAL BACKGROUND (Optional)

Are you a part of a local faith community? Yes No If so, which one? _____

How would you rate your current interest in spiritual growth?



Problem Areas

Place a check mark next to each item that identifies an area of concern to you. Place two checks next to those that are most important. Please circle or underline to clarify your choice or add additional comments.

- | | |
|---|---|
| <input type="checkbox"/> I have no problems or concerns | <input type="checkbox"/> Irresponsibility |
| <input type="checkbox"/> Abuse (physical, sexual, emotional) or neglect | <input type="checkbox"/> Isolation / withdrawal |
| <input type="checkbox"/> Aggression, violence, threats | <input type="checkbox"/> Judgment problems/risk taking |
| <input type="checkbox"/> Alcohol or drug abuse | <input type="checkbox"/> Legal matters |
| <input type="checkbox"/> Anger / Frustration, hostility, arguing, irritability, temper problems | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Anxiety, nervousness, panic, tension | <input type="checkbox"/> Low energy/motivation or fatigue |
| <input type="checkbox"/> Career/work concerns, goals, choices | <input type="checkbox"/> Low self-esteem, inferiority feelings |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Marital problems (conflict, distance/coldness, infidelity/affairs, remarriage) |
| <input type="checkbox"/> Children (child management, childcare, parenting, custody of children) | <input type="checkbox"/> Menstrual problems, PMS, menopause |
| <input type="checkbox"/> Codependence | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Confusion, thought or memory problems | <input type="checkbox"/> Obsessive / compulsive behavior, compulsions |
| <input type="checkbox"/> Depression, low mood, sadness, crying | <input type="checkbox"/> Oversensitivity to rejection/criticism, shyness |
| <input type="checkbox"/> Difficulty trusting others, suspiciousness | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Easily agitated / annoyed | <input type="checkbox"/> Physical problems, headaches, other pains |
| <input type="checkbox"/> Eating difficulties-overeating, under eating, appetite disturbance, vomiting, weight, diet | <input type="checkbox"/> Poor concentration, attention, distractibility |
| <input type="checkbox"/> Education | <input type="checkbox"/> Problems with parents |
| <input type="checkbox"/> Emptiness | <input type="checkbox"/> Sleep disturbances (too much, little, insomnia) |
| <input type="checkbox"/> Failure | <input type="checkbox"/> Social/interpersonal conflicts |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Stress, tension |
| <input type="checkbox"/> Fears or phobias | <input type="checkbox"/> Substance abuse by another person |
| <input type="checkbox"/> Financial or money troubles, debt, impulsive spending, low income | <input type="checkbox"/> Thoughts of hurting others |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Thoughts of hurting yourself |
| <input type="checkbox"/> Grieving (mourning, deaths, losses, divorce) | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Heart pounding / racing | <input type="checkbox"/> Trembling / shaking |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Unpleasant thoughts won't go away |
| <input type="checkbox"/> Impulsiveness, lack of control | <input type="checkbox"/> Worthlessness |
- Other: _____
-

Center Point

Informed Consent and Description of Fees and Services

Counseling is a cooperative venture with responsibility resting on both therapist and client. Please carefully read the information below.

If you have any questions, your therapist will be happy to discuss them with you.

CLIENT RIGHTS: You have the right to decide not to enter therapy and may end therapy at any time. You have the right to ask questions to your therapist at any time regarding the treatment you are being provided and to receive answers that are clear and satisfactory to you. You have the right not to allow the use of any therapy intervention/technique. You have the right to confidentiality in treatment with certain exceptions (see below). You have the right to review your records and to receive a copy of your file.

LIMITS TO CONFIDENTIALITY: In general, communications between client and therapist are confidential. Such information will not be released to anyone, including other agencies, without your written consent. There are some limitations, however, to confidentiality. As mandated reporters, Georgia state law requires that therapists report to the appropriate authorities any suspected abuse (including sexual abuse, physical abuse, and neglect) of a minor, older adult, or disabled/dependent adult. Mandated reporters are also required to report imminent risk of suicide and threat(s) of homicide. In addition, if a therapist receives a subpoena or court order to testify in a legal matter in which a client is involved, the therapist must respond. In the event a medical emergency occurs in the therapy office, emergency medical professionals will be contacted immediately. If you choose to use your health insurance to cover part or all of the cost of treatment, Center Point must reveal: A) The fact that you are a client; B) The primary diagnosis for which you are receiving treatment.

SESSION LENGTH: The therapeutic session lasts 45-52 minutes. The additional time is used for scheduling the next appointment, receipt of payment and charting of your session.

CANCELLATIONS: Regular attendance will produce the maximum possible benefits. If you must cancel, please call your therapist or phone the center at (770) 535-1050 and leave a message on the voice mail at least 24 hours in advance of your scheduled appointment. *A missed appointment fee will be charged for cancellations received less than 24 hours in advance.*

LATE/MISSED APPOINTMENTS: Therapists are scheduled to see clients hourly. Therefore, it is necessary to be prompt for your session. *If a client chooses to arrive late, only the remainder of the scheduled session time will be utilized and the client will be billed for the time spent in session. If a client is more than 15 minutes late, the appointment will be rescheduled, and the client will be charged a missed appointment fee. If a client fails to attend an appointment, including a first appointment, a credit card must be placed on file before another appointment is made. Clients who fail to attend their second intake appointment will be charged a missed appointment fee.*

TELEPHONE CALLS: Your therapist will provide you with a contact number where you can leave a confidential message for him/her. When calling, please leave your name and telephone number (even if we already have it on file). Your call will be returned in a timely manner.

EMERGENCY PROCEDURES: In order to insure prompt attention during an emergency situation in which you are unable to contact your therapist, you will need to contact the **Northeast Georgia Medical**

Center at (770) 535-3553, where emergency mental health personnel are available 24 hours a day. Please dial **911 for immediate assistance**.

PAYMENT: Payment is due on the date of your appointment and can be made via cash, check or credit card. Please make all checks payable to Center Point. There is a fee of \$25 for any check returned due to insufficient funds. Out-of-pocket fees for services are as follows: Masters Level Clinicians - \$150/intake, \$125/session for 1 hour and \$100/session for 45 minutes. Doctoral Level Clinicians - \$175/intake, \$150/session for 1 hour and \$125/session for 45 minutes. A list of atypical fees (e.g., lengthy phone calls or court costs) is available upon request.

INSURANCE: Only licensed clinicians on staff can accept insurance. There are many variations for individual insurance plans including deductibles, co-pay amounts, and co-insurance amounts. Center Point will contact your insurance company to learn what amount you are responsible for per session and will process insurance claims on your behalf. Ultimately, however, you are responsible for payment if for some reason your claim is denied even if you are no longer receiving services at Center Point. If we do not receive your health insurance information at least 2 full business days prior to intake and are unable to verify benefits before the end of your first session, you may be charged the full out-of-pocket (non-insurance) rate for that session. If benefits can be verified later, you may receive a credit for any amount over the contracted (insurance) amount. If we are not a provider for your insurance company, and you have out-of-network benefits that you wish to access, we will bill your sessions on your behalf. ***Please be aware, however, that unlike in-network benefits, there is no contracted rate for your sessions and any difference between what your insurance company covers and our rates (see above) is your responsibility.***

By signing below, I consent to receiving treatment as described in this form, accept the forms of communication noted above, acknowledge that this form and its contents will become a part of my medical record, and agree with these terms and conditions:

- 1) _____ is the amount I am expected to pay per session.
- 2) \$50 is the missed appointment fee I have agreed to pay and I understand that this will not be paid by insurance but is my responsibility
- 3) By providing a credit card for payment, I am consenting to the information being stored securely and to it being used to cover the cost of treatment including missed appointments unless other arrangements are made at the time of service.
- 4) I have been offered and/or reviewed a copy of Center Point's Notice of Privacy Practices
- 5) I have been informed that Center Point is in compliance with the Health Information Portability and Accountability Act (HIPAA)

** For those clients accessing their health insurance benefits*

- 6) I consent for Center Point to release healthcare information necessary to process my insurance claims
- 7) I hereby authorize payment directly to Center Point for any benefits due for treatment
- 8) I agree to tell my therapist about any changes in my health insurance

Client Signature: _____ Date: _____

*Signature of the custodial parent or guardian is required for clients under 18 years of age.

Staff Therapist: _____ Date: _____