Heritage Counseling, Inc.

1009 N. Columbia Ave.
Rincon, GA 31326
912-657-9613

Date: _____

To: _____
_____
_____

PLEASE KEEP THIS COVER SHEET FOR YOUR RECORDS

Dear _____,

We are pleased that you have chosen Heritage Counseling, Inc. for your counseling needs. Enclosed you will find an initial visit information sheet, an information disclosure sheet, an informed consent notice and if applicable to you, permission for your counselor to speak with your child. Additionally, if you are transferring from counseling with another therapist or would like to have our counselors share your information with a third party (for example, your attorney, spouse, ect.), please ask us for a Request/Release for Information form.

In order to expedite your visit with your counselor please have these forms completed upon your arrival for your first visit. If you will be using your insurance to pay for your services please contact your insurance company to determine coverage. Clients whose insurance does not cover our service will be expected to pay the session fee at the time of their visit unless other arrangements have been made with the office manager. Please note that failure to cancel an appointment within 24 hours of your session will result in your being billed for that session. You may call our offices between 9:00AM and 5:00PM and speak directly with our administrative staff. You may also leave a message on our answering machine during non-business hours.

Again, thank you for your interest in Heritage Counseling and we look forward to seeing you at

_____ on _____ .

Sincerely,

Tracey E. Pace, Th.D., Med. MSA, LPC, NCC

President, Heritage Counseling

Heritage Counseling, Inc.

General Information / Consent to Treat:

This is a professional counseling facility. We offer professional counseling to individuals struggling with a variety of issues. Professional counselors, social workers, and therapists that are licensed by the State of Georgia perform our counseling. Our counselors have earned a master's degree (or higher) in counseling, psychology or a closely related field from an accredited institution. Therapy can last from a few weeks to several months. Most people find therapy very helpful, however, depending on the nature of your difficulty, you might also experience uncomfortable emotions such as anger, fear, and frustration during the course of your counseling. While your counselor cannot remove these feelings from you, they will help you work through them, or find an alternative counselor. You are free to discontinue therapy at any time. Most people remain in therapy until they feel that they have learned better methods of thinking, feeling, and/or acting regarding their difficulties. Occasionally, the therapist elect to discontinue therapy. This usually happens when they feel that no substantial progress is being made or other factors are interfering with their ability to help you. If therapy ends prematurely, we will help you find qualified help elsewhere. Under normal circumstances everything you discuss with your counselor will be held in strict confidence. However, you should be aware that there are some situations in which your counselor may be required by law to report information to the proper authorities without your permission or knowledge. These situations include but may not be limited to a client's indication of bodily harm to others, suicidal intentions, and reasonable suspicion of child or elder abuse or neglect. Your counselor may also disclose information in response to a subpoena issued by a court of law.

_____
Initial

If you require your counselor to appear in court for any reason, you will be billed an hourly fee of $150 and arrangements must be made in advance of the court date.

Are you currently involved or foresee any legal proceedings or court appearances?

Yes or No

If yes, did your attorney recommend you see a counselor? Yes or No

If so, which attorney? _____

_____
Initial

Our counselors schedule their appointments to limit you waiting time. We will not require you to wait for another patient who has shown up late for his/her appointment. Our sessions are typically 55 minutes with 5 minute breaks between. Since we can only schedule one patient per hour we require that you cancel any scheduled appointments 24 hours prior to the scheduled time. Failure to cancel a scheduled appointment will result in you being billed for the entire fee.

_____
Initial

We offer Saturday appointments for the convenience of our patients. Our therapists adjust their personal schedule to accommodate these appointments. Therefore, we require all Saturday appointments to preauthorize a credit card should you fail to cancel your appointment at least 24 hours prior to your scheduled appointment or do not show. Your card WILL NOT be charged unless the cancellation policy is not complied with.

_____
Initial

RECORDING OF ANY KIND IS STRICTLY FORBIDDEN WITHOUT THE CONSENT OF ALL THE PARTIES INVOLVED.

"I understand the above issues and agree to receive counseling services from Heritage Counseling, Inc."

_____ _____

Signature of Client Date

Heritage Counseling, Inc.

Counseling Minor Children:

I, _____, give my permission for Heritage Counseling, Inc. to see my son/daughter _____ with or without my being present during sessions. I/We understand that we have the right to control the disclosure of private counseling information about my/our child.

Are the biological or adoptive parents of the child or children currently married to each other? Yes or No

_____ _____

Signature of Parent Date

NEVER MARRIED, DIVORCED, DIVORCING AND CUSTODY CASES:

Are the child's parents going through a divorce or custody issue? Yes or No

If divorced, disputing custody, or never married:

Name and contact information (if available) for the other parent:

_____

_____

_____

Does the other parent have legal rights to the child or children? Yes or No

Does the other parent have custodial rights to the child or children? Yes or No

Due to the sensitive nature of divorce and all potential issues that may arise in such cases, we have very specific policies regarding counseling minors:

_____ If we are counseling a child whose parents are in the process of divorce or already divorced, we require a copy of the standing court order demonstrating the legal and custodial rights of each parent and/or the parenting agreement signed by both parents and judge.

_____ Summaries of the child's therapy progress, treatment plan, and parent recommendations are available to both parents who share in the legal custody of the child client. We will offer and encourage opportunities for both parents to participate in parent consultations along the way unless your therapist believes that involving both parents in counseling would not be beneficial to the child.

Heritage Counseling, Inc.

General Information Form:

PATIENT INFORMATION

Patient's Name:			DOB:
Street Address:	City:	State:	Zip:
Parent or Guardian (If Minor)/Spouse	Home Phone: Cell: Work:		

Emergency Contact

Name:

Relation to Patient:

Phone:

May we leave a message via:

Voicemail:_____ Email:_____ Text:_____

Email Address:

MEDICAL HISTORY

Primary Care Physician:	Psychiatrist (If Applicable):
How would you rate your physical health? Excellent:___ Good:___ Fair:___ Poor:___ Very Poor:___	List of Current Medications:
Are you experiencing any physical problems?	
Have you ever been hospitalized for an emotional illness? If yes, please explain:	
Have you ever sought professional counseling before? If yes, when, why , and with who?	
Are you now seeing another counselor? If yes, who?	

Heritage Counseling, Inc.

General Information Form Continued:

PRESENT SITUATION

List any behaviors that you consider problematic:

List any emotions or feelings that OTHERS consider problematic:

How long have you been experiencing this difficulty?

How difficult do you believe this problem is?

Just an Irritant:_____ Mildly Upsetting:_____ Severe or Incapacitating:_____

INSURANCE INFORMATION

Are you covered by behavior health or mental health insurance? Yes ___ No ___		Insurance Company:
Name of Policy Holder:	Policy Holder's DOB:	Policy Holder's SSN (Needed for Tricare):
Policy Holder's Employer:	Policy Holder's Address: Street: City: State: Zip:	

MISCELLANEOUS INFORMATION

You may use the space below to include continued information or additional information:

Heritage Counseling, Inc.

Consent to Disclose Information:

THIS FORM IS CONSENT FOR OUR CENTER TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Patient Name:_____ Date of Birth:_____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations.") Nevertheless, I ask for your consent of disclosure in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

The Privacy Rule permits covered entities to continues to use the services of debt collection agencies. Debt collection is recognize as a payment activity within the "payment" definition. See the definition of "payment" at 45 CFR 164.501. Through a business associate arrangement, the covered entity may engage a debt collection agency to perform this function on its behalf. Disclosures to collection agencies are governed by other provisions of the Privacy Rule, such as the business associate an minimum necessary requirements.

I acknowledge that I have been given a copy or the opportunity to review a printed set of my HIPAA privacy rights.

Signature of Patient:_____

Date:_____