HERITAGE COUNSELING, INC.

1009 N. Columbia Avenue

Rincon, GA 31326

912-657-9613

Date: __________________

To: _____________________________________
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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 currently in counseling with another therapist or would like to have our counselors share your information with a third party (for example, your attorney, spouse, etc.), 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 center. 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 a secretary. You may also leave a message on our answering machine during non-business hours.

As a business owner or a manager of a household or family you understand that cash flow is vital to the survival and success of an entity. We believe that we provide valuable services at competitive rates for our region. In order to continue to provide services we must receive payment for the services we render so that we may pay personal salaries, technology, education and overhead. If payment is not received within 30 days, a late charge of 1.5% interest will be charged monthly until paid in full. If payment is not received within 60 days, we will notify you of your options. You may pay in full or sign a promissory note installment agreement within 14 days of notification, or we may turn your account over to a collections agency.

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

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 therapists, licensed by the State of Georgia and NBCC certified counselors, perform our counseling. Our counselors have earned a master's degree (or higher) in counseling psychology or a closely related field from a regionally 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 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 therapists 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, involvement in a felony, suicidal intentions and reasonable evidence of child or elder abuse or neglect. Your counselor may also disclose information in response to a subpoena issued by a court of law.

If you require your counselor to appear in court for any reason, you will be billed an hourly fee and arrangements must be made in advance of the court date. Please speak with your counselor about this if you anticipate the need for his/her appearance in court.

Our counselors schedule their appointments to limit your 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 50 minutes with 10 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. Understand that if payment for services is not received within 60 days, we will notify you of your options. You may pay in full or sign a promissory note installment agreement within 14 days of notification, or we may turn your account over to a collections agency.

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 charge should you fail to cancel your appointment at least 24 hours prior to your scheduled appointment. Your card WILL NOT be charged unless the cancellation policy is not complied with.

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

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

____ ____________________

Signature of Client Date

Consent to Counsel a minor:

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 child.

____ _____________________

Signature of Parent/Guardian
Date

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

If you answered "no" to the above question, does the other biological parent have legal rights to the child or children? Yes or No

If the other biological parent has legal rights to the child or children, they do have the right to information regarding the counseling of their child or children.

A copy of the court order in regards to custody and legal rights will be required.

HERITAGE COUNSELING, INC.
General Information Form

PATIENT INFORMATION

Patient's Name:		SSN:
Street Address:	City:	State:
Parent/Guardian (If Minor)/Spouse:	Home Phone:	Cell:
Emergency Contact Name/Relation to Patient:	May we leave a message via: Voicemail ____ Email ____ Text ____	
Emergency Contact Phone:	Email Address:	

MEDICAL HISTORY

Family Doctor:	List of Current Medications:
How would you rate your physical health? Excellent __ Good __ Fair __ Poor __ Very Poor __	
Are you experiencing any physical problems?	
Have you ever been hospitalized for an emotional illness? If yes, please explain:	

EMOTIONAL HISTORY

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 Cont.

PRESENT SITUTAION

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 Street Address:	City:	State:

MISCELLANOUS INFORMATION

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

CONSENT 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 your consent 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 continue to use the services of debt collection agencies. Debt collection is recognized 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 and minimum necessary requirements.

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

Signature of Patient: ____

Date: _______________

Heritage Counseling, Inc.