The Veal Group

Counseling • Coaching • Consulting
401 Ridley Avenue, Suite 3
LaGrange, GA 30240
(706) 756-1970

Name: _____ Date: _____

Address: _____
Street Apt. #

_____
City State Zip Code

Date of Birth: _____ Current Age: _____ Male Female

Preferred Phone: _____
May we send appointment reminders in the form of a text message to this phone? Yes/No
May we leave a voicemail message on this phone? Yes/No

_____
Email Address

IN CASE OF EMERGENCY			
Name of Friend or Relative (for minors list at least one parent)	Relationship to Client	Contact Number	Is it ok to leave a message?

Client Financial Agreement & Contract

The Veal Group, LLC is committed to providing quality services at an affordable cost. Please, carefully review the following information to ensure you have a clear understand of the cost associated with counseling.

Session Appointments and Attendance: _____ (initial)
Appointments are reserved for each client for a full clinical hour (50-minutes). If you do not show up for this appointment and you do not cancel your appointment 24-hours in advance, you will be billed for this appointment in full.

Once an appointment is scheduled, you will be expected to pay for it unless you provide 24-hour notice of cancellation. Failure to give a 24-hour notice of cancellation will result in being billed for the full amount of the appointment. It is important to note that insurance companies and benevolence funds cannot be billed for missed appointments and do not provide reimbursement for missed appointments. Therefore, the client will be responsible for the full amount of all missed appointments that are not cancelled within the 24-hour time frame.

Fees and Payments: _____ (initial)
My hourly fee is $ __100.00__ per clinical hour.
A sliding scale is offered to those individuals who are eligible. To see if you qualify for a sliding scale, please ask your therapist for further information. For this counseling relationship I, _____ (initials), agree to pay a rate of _____ per session, which has been agreed upon by the counselor _____ (counselor initials).

Payment is due at the time of service. Payment may be made in the form of checks, cash, and credit/debit. Checks may be made payable to: The Veal Group. You will be charged bank fees for returned checks. If credit/debit is used there will be a $3.00 processing fee applied to the total charge.

All unpaid balances are due within 30 days of the last appointment. Balances past 90 days will be turned over to a third party collections agency. A collection fee of $50.00 will be added to the unpaid balance. If you have difficulty paying unpaid balances within 30 days, please bring this to my attention so we can discuss the issue and arrange for a payment plan if needed.

Court Testimony: _____ (initial)
If your involvement in legal matters requires me to be subpoenaed to court on your behalf, you will be charged $1,000 for a full clinical day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one day, would be billed at the rate of $100.00 per hour including travel time. You are responsible for and agree to pay these charges whether or not I ultimately testify. The reason for this is that preparation for court is a lengthy process that I like to adequately prepare for. Additionally, if I commit to attending court for you therefore, I cannot schedule other clients on that date.

Credit/Debit Card Information:
I, _____ (initials), authorize The Veal Group, LLC to keep the credit/debit card information below on file, and I authorize The Veal Group, LLC to charge the card for late cancellation fees or nonpayment.

I, _____ (initials), authorize The Veal Group, LLC to charge any outstanding balance to the credit/debit card on file if I have not contacted my therapist to arrange an alternative payment method within 48- hours after a late cancellation or a missed appointment.

I, _____ (initials), certify that my information is true, accurate, and that I am an authorized user on the account.

Circle the type of card that applies: 

Card Number																			

Expiration Date (mm/yyyy)		CVC Code		
Cardholder Name (as it appears on the card):				
Billing Address for the card:				
Billing City:		Billing State:	Billing Zip:	

Your signature below indicates that you have received, read, understand your rights and responsibilities under this financial agreement and agree to enter a counseling relationship with The Veal Group, LLC upon the terms of this agreement.

Client Signature: _____ Date: _____

Printed Name: _____

Counselor Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES
(KEEP THIS FOR YOUR RECORDS)

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information use or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose our medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** includes the business aspects of running our practices, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service. An example would be an internal quality assessment review.

We may also create and duplicate de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your Protected Health Information (PHI), which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by your signature. We are, however not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of PHI.
- The right to obtain a paper copy of this notice upon request.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. This notice is effective as of October 1, 2007 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all PHI that we maintain. You may request a written copy of a revisited Notice of Privacy Practices. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information: The Veal Group 401 Ridley Ave, Suite 3 LaGrange, GA 30240 Phone: (706) 756-1970	For more information about HIPAA or to file a complaint The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S. W. Washington, DC 20201 Toll Free (877) 696-6775

Client Signature Client Printed Name Date

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Adult Intake

COUNSELING CONCERNS
What are the concerns that have lead you to seek counseling? Please be specific:
1)
2)
3)
4)
How do you currently handle your issues?:
What things do you believe you do well? (e.g. strengths, activities, talents)

COUNSELING GOALS
Goals are very important in counseling. They provide your therapist with a focus and direction that will help us to help you. Please list the goal(s) that you want to address and reach in counseling. Please be specific as possible.
1)
2)
3)
4)

MENTAL STATUS								
sad	anxious	depressed	frightened	guilty	angry	ashamed	aggressive	extreme ups
worthless	resentful	tearful	irritable	confused	jealous	hopeless	annoyed	extreme downs

Describe any other feelings you have had:

What activities or hobbies do you participate in?

Do you participate in regular exercise? YES / NO If yes, describe:

Who is in your support network?

Have you had any change in sleeping habits? YES / NO If yes, describe:

Have you had any change in eating habits? YES / NO If yes, describe:

Have you ever **considered or attempted suicide** in connection to a **current or past** problem?
If so, please give a brief description with dates:

Have you had any **homicidal thoughts or attempted homicide** in connection to a **current or past** problem?
If yes, please explain:

Do you have access to any guns or other weapons? YES / NO
If yes, please explain:

LEVEL OF FUNCTIONING
List or describe any current issues or problems in daily psychological, social or occupational functioning (i.e. isolation from friends or family, significant difficulty getting work or completing daily tasks, severe financial strain, recent divorce and problems with supervisor, etc.):
THOUGHTS: Please check any of the following that apply to you:
_____I sometimes hear voices even though no one nearby is talking to me.
_____I sometimes feel that forces outside of me control me.
_____I sometimes feel that other people control my thoughts.
_____I sometimes have the same thought over and over and cannot control it.
_____I sometimes feel that someone is out to hurt me or do something against me.
_____I am sometimes unable to control my behavior. Please explain:

V

LEGAL/SUBSTANCE HISTORY
Have you ever been convicted of a crime? Yes / No Misdemeanor / Felony If yes, please explain:
Are you on parole or probation, deferred adjudication or under a pre-trail diversion agreement? Yes / No If yes, please explain:
Have you ever thought or been told that you may have an issue with pornography?

Do you smoke cigarettes? Yes / No	Do you used other forms of tobacco? Yes / No If yes, what kind?

Do you drink alcohol? Yes / No
Have you ever thought or been told that you may have a problem with alcohol?

Type of Alcohol	How Much?	How often?

Do you use recreational drugs? Yes / No
Have you ever thought or been told that you may have a problem with drugs?

Type of Drug (Marijuana, Cocaine, etc.)	How much?	How often?

MEDICAL HISTORY

Last time you saw Primary Care Physician:	Last time blood work was done?

Have you ever seen a counselor, therapist, or psychiatrist? Yes / No If yes, when and how long?

Provider name, focus of treatment:	Helpful?

Have you ever been given a mental health diagnosis in the past? If yes, what?

Have you ever been hospitalized for medical or psychiatric reasons?
If yes, please explain:

Describe any important medical history, chronic ailments or other health problems you experience:

List current medications being taken. Please include over-the-counter, vitamins, and herbal medication.

Medication Name	Dosage / Frequency	Length of Use	Purpose

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety or other emotional difficulties? Please list:

V

FAMILY HISTORY	
Mother: _____ (Name)	Father: _____ (Name)
Living / Deceased	Living / Deceased
Marital History:	Marital History:
Is someone else (step-parent, grandparent, etc.) considered to be one or both "real" parents? If so, whom?	
Relationship with mother while growing up:	
Describe Current Relationship:	
Relationship with father while growing up:	
Describe Current Relationship:	

List first names and ages of siblings:

Name	Age	Relationship

Describe any family problems related to:

Alcohol/drug abuse:

Sexual/physical/emotional abuse:

Others (not listed above) living in the home / Additional Family History

EDUCATION HISTORY
Any developmental, academic, or behavior problems as a child or currently in school, with peers or teachers? If yes, please explain:
Educational History:

MARITAL HISTORY (if applicable)			
Marital status: Single/Never Married Married Separated Divorced Widowed Living w/someone: _____			
Marital History:			
Divorce History:			
Please list your children:			
Name	Age	Relationship (biological/step)	Lives with

EMPLOYMENT HISTORY	
Are you currently employed? Yes / No How Long?:	Company, Position:
Describe your current work environment:	
Employment history:	