Adult Intake Packet

- Client Information Form
- Financial Information Form
- Credit Card Authorization Form
- Cancellation Policy
- Confidentiality Agreement
- HIPAA
- Consent to Treatment
- Consent to Psychological Evaluation (If Applicable)

Client Information Form

To assist us in providing services to you, please complete this form as fully and openly as possible. All private information is held in the strictest confidence within legal limits. **If certain questions do not apply, leave them blank**. Some of the information is required by our accrediting and licensing agencies. **If you need help completing this form, please do not hesitate to ask.** Thank you for your cooperation.

Today's Date:_____Birth Date:_____ Social Security #:_____

Name:_____ Age:_____ Gender: M F Race/Ethnicity:_____

Email Address: _____

Mailing Address: _____

Physical Address: (if different)_____

County:_____ City:_____ State:_____ Zip:_____

Do you live in a [ ] House [ ] Apartment [ ] Mobile Home [ ] Other _____

We may need to call you to remind you of an appointment or to change an appointment.

May we leave a message (*Please Circle*)? Yes No

What is the best number to leave a message and contact you?_____
What number may we reach you by text for appointment confirmations?_____
Annual Household Income:_____

Who currently lives in your household?

Name	Age	Relationship	Gender

What is/are the main reason for this visit? _____

_____

_____

OCCUPATIONAL

Current means of financial support (check all that apply):

[ ] Self [ ] Family [ ] Parents [ ] Spouse [ ] Children [ ] Retirement benefits [ ] Welfare [ ] Disability

Employment Status:
[ ] employed full-time [ ] part-time [ ] unemployed [ ] disabled [ ] retired [ ] student

Current employer:_____Phone:_____

Your current position:_____Date Began:_____

YOUR CHILDREN

Name	Male/Female	Age

_____

Who has custody of your children? _____

Are there custody issues or problems? [ ] Yes [ ] No If yes, please explain._____

_____

ABUSE HISTORY

Have you been a victim of any of the following types of abuse? If yes, please indicate by whom, the duration, and your age at the time of the abuse.

		By Whom?	Duration	Your Age
Physical Abuse	[ ] Yes [ ] No			
Sexual Abuse	[ ] Yes [ ] No			
Emotional Abuse	[ ] Yes [ ] No			
Neglect/Abandonment	[ ] Yes [ ] No			

Have you ever abused anyone? [ ] Yes [ ] No
If yes, please describe._____
_____

Have you ever been a victim of ANY other crime? [ ] Yes [ ] No
If yes, please describe._____
_____

Is there a family history of:
Substance abuse [ ] Yes [ ] No Describe_____
Suicide [ ] Yes [ ] No Describe_____
Violence [ ] Yes [ ] No Describe_____

Psychiatric Problems [ ] Yes [ ] No Describe_____
Criminal Activity [ ] Yes [ ] No Describe_____

SUBSTANCE USE/HABITUAL BEHAVIOR

Do you use nicotine? [ ] Yes [ ] No Type: [ ] Cigarettes [ ] Cigars [ ] Smokeless
How long have you used nicotine? _____ How much per day? _____

Do you use alcohol? [ ] Yes [ ] No
If yes, how frequent? _____
How much each time? _____

Type of use: [ ] Social [ ] Recreational [ ] Abusive [ ] Problematic [ ] Addicted

If you do not currently use alcohol have you in the past? [ ] Yes [ ] No
If yes, how frequent?_____
How much each time?_____

Type of use: [ ] Social [ ] Recreational [ ] Abusive [ ] Problematic [ ] Addicted

Do you currently or have you in the past used street drugs or abused prescription drugs? [ ] Yes [ ] No Details:_____

Do you have any other addictive or compulsive behaviors (eating, gambling, etc.)?_____
_____

MEDICAL HISTORY

Primary care physician:_____
Address:_____

Are you under the care of a psychiatrist: [ ] Yes [ ] No If so, whom:_____

Other important healthcare providers:_____

Please list any medical conditions?_____

Date of last physical:_____Hearing exam?_____ Eye Exam?_____

What kinds of physical exercise do you get?_____

Due you restrict your eating in any way, if so, how and why?_____
_____

Do you have any problems getting enough sleep, if so, what problems?_____
_____

HOSPITALIZATIONS (PHYSICAL OR MENTAL HEALTH)

Hospital	Dates	Reason

OUTPATIENT MENTAL HEALTH TREATMENT

Facility/Therapist Dates Reason

_____

_____

_____

_____

Allergies:_____

ALL MEDICATIONS: (prescribed, over-the-counter, vitamins, herbs)

Medication Dose Reason Prescribing Physician

_____

_____

_____

_____

_____

_____

RELIGIOUS/SPIRITUAL CONCERNS

What is your religious preference?_____

How important is spirituality/religion in your life?

Not at all				Somewhat					Extremely
1	2	3	4	5	6	7	8	9	10

Do you have any concerns related to spirituality or religion?_____

_____

_____

LEGAL CONCERNS

Are you involved in any active cases (traffic, civil, criminal)? ____Yes ____No

If YES, please describe and indicate the court or hearing/trial dates and charges:_____

_____

Are you now or have you ever been on probation or parole? ____Yes ____No

If YES, please describe:_____

_____

MILITARY HISTORY

Military Experience? ____Yes ____No Combat Experience? ____Yes ____No
Branch of Service_____ Duty Station(s) _____
Current Military Status: ____Active ____Retired ____Reserves ____Nat'l Guard ____Discharged
If Discharged: Rank at time of Discharge_____ Type of Discharge_____

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g. art, books, music, crafts, physical fitness, outdoor activities, church activities, etc.)_____

Is there anything else you would like the counselor to know that has not been covered?

Financial Information Form

I truly appreciate your choosing to come to me for psychological help. If you have health insurance, it may pay for a part of the cost of your treatment here. In order for our office to verify your insurance benefits, please complete this form. We will explain any part of this form that you do not understand.

A. Patient's name: _____ Birthdate: _____Soc. Sec. #: _____
Address: _____Home phone: _____
(If the patient is a dependent) Insured's/policy holder's name: _____

Occupation:_____Employer: _____

Work phone: _____

Address of employer:_____

B. (If applicable) Spouse's name: _____Birthdate: _____

Soc. Sec. #: _____Occupation:_____Employer: _____ Work phone: _____
Address of employer:_____

C. INSURANCE:

Primary Insurance Co: _____Insured's Name: _____

Date of Birth:_____Insured's SS#:_____

Address (Where to mail claim): _____
Phone:_____ID No. _____Group No. _____

(If applicable) Authorization #:_____

Secondary Insurance Co: _____Insured's Name: _____

Date of Birth:_____Insured's SS#:_____

Address (Where to mail claim): _____
Phone:_____ID No. _____Group No. _____

Note: We can only give you information based on what we are told by your insurance company on the day we call. Benefits are always based on your actual coverage on the date of service.

D. To Check Insurance Benefits

In order to determine if your benefits will cover your counseling and/or psychological testing services, we will be asking your insurance company the following questions: Does this patient have benefits for outpatient behavioral health and/or psychological testing? Is this provider considered in or out of network? If out-of-network, does this patient's plan cover services with an out-of-network provider? What is the patient's deductible, and has it been met? Does the patient have a copay and/or coinsurance? Do any limits apply to the number of sessions that are covered? Are any authorizations required?

E. If you do not have insurance, how will you pay for services from this office? _____

F. I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

G. I understand that I am responsible for all charges, regardless of insurance coverage.

H. Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to therapist above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Client's (or parent/guardian's) signature, indicating agreement to all of the statements above

Date

_____

Printed Name

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Credit Card Authorization Form

Cardholder name: _____

Billing address: _____

(street)_____

(city)_____ (state)_____(zip)_____

Credit Card Type: _____Visa _____ Master Card _____ Discover ____Amex

Credit Card number: _____

Expiration date: _____

Card Identification Number (last 3 digits on back of card): _____

Amount to charge: _____ (USD)

I authorize Dr. Kelly M. Lewis of GlobeCore Inc. to charge the agreed amount listed above to my credit card provided herein. I agree that I will pay for this service in accordance with the issuing bank cardholder agreement. I understand and agree to my credit card being charged for the full amount should I miss my appointment or not give a full 24 hours' notice of cancellation. This authorization may be revoked upon providing a written statement.

Print Name: _____

Sign Name: _____

Date: _____

CANCELLATION POLICY

Because I often have a waiting list of clients seeking appointments, I must require at least 24 hours notice prior to canceling an appointment. If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. Insurance companies do not pay for missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Today's Date

My signature below indicates that I have discussed this form with my counselor and they have answered any questions that I have pertaining to this information.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Today's Date

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CONFIDENTIALITY AGREEMENT

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances: Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable): Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above confidentiality agreement and understand its meaning and ramification.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

HIPAA Policy

Notice of GlobeCore Inc.'s Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment, and Health Care Operations*"

  – *Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist. Another example would be when we release your treatment plan to your insurance company and/or to your primary care physician.

  – *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about your conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.

- *Adult and Domestic Abuse* – If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authority.

- *Health Oversight Activities* – If we are the subject of an inquiry by the Georgia Board of Psychological Examiners, we may be required to disclose protected health information regarding you in proceedings before the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If we determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

- *Worker's Compensation* – we may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing therapists. On your request, we will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

- If we revise these policies and procedures, we will notify you by mail or on your next session.

V. Complaints

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Kelly M. Lewis, Ph.D., Lillian Morgan- Lewis, or SueEllen D. Hollowell, MPH. at *GlobeCore, Inc.* You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Dr. Lewis, Mrs. Morgan-Lewis, or Ms. Hollowell can provide you with the appropriate address upon request.

VI. Cancellation Policy

In the Event of an emergency, you will not be charged for session cancellation. Cancellations for any other reasons that are not received by center staff at least 24 hours prior to the scheduled session will be billed at the usual hourly rate. Your insurance company will not pay for missed appointments.

HIPAA Policy

Notice of GlobeCore Inc.'s Policies and Practices to Protect the Privacy of Your Health Information

My signature attests that I have received a copy of and read the HIPPA Policy provided to me by GlobeCore, Inc.

Printed Name of Client	Witness
Signature of Client and/or Guardian	Date
Printed Name of Client (under 18)	Date
Signature of Client (under 18)	Date

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CONSENT TO TREATMENT

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor are any sort of trade of service for service.

AVAILABLE SERVICES: GlobeCoRe, Inc. offers a wide array of psychological services, including individual, family, couples, and group services. Our counselors are trained as licensed clinical psychologists or licensed clinical psychologists in training. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness; however the benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course. However, it is my desire to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: Our therapists provide short and long-term counseling designed to address many of the issues my clients are dealing with. Your first visit will be an assessment session in which you and your therapist will determine your concerns/goals, and if you both agree that your therapist can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment that is provided, further treatment may be terminated.

Our goal is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your therapist are not a good fit, please discuss this matter with your therapist to determine if transferring to a more suitable Therapist is right for you. If we decide that other services would be more appropriate, your therapist will assist you in finding a provider to meet your needs. Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of one's physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and

happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on an as needed basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate. Once your appointment is scheduled, you will be expected to pay for it (even if it is missed) unless you provide 24--hour advance notice of cancellation (See the Cancellation Policy at the end of this form). If you have a health benefits policy, it will usually provide some coverage for mental health treatment when a licensed professional provides such treatment but your insurance will not pay for missed or cancelled appointments.

FEE SCHEDULE:

Psychiatric Intake (1st visit)	$150.00
Regular Office Visits (60 minutes)	$150.00
Regular Office Visits (45 minutes)	$125.00
Psychological Evaluation	$200.00/hour
Outside Office Work (inpatient visits, court, collaborative law services, insurance companies, letters or phone calls to Attorneys concerning you or your children, etc.)	$300.00/Hr.(Prorated)
Returned check fee per check	$35.00

A reasonable fee will be charged for copies of any records requested by the Client.

COURT APPEARANCES/SUBPOENAS: Kelly M. Lewis, Ph.D. (GlobeCoRe, Inc.) **will not** voluntarily appear in court or provide written statements on behalf of any of her clients.

For counseling to be truly effective and beneficial to the client it must be preserved in an atmosphere of honesty, self-reflection, openness, and comfort for the client and therapist. When there is a threat of court interaction (subpoenas and/or summons for separation, divorce, custody, legal actions, disability claims, etc.) this therapeutic relationship is compromised. By signing this statement, you are waiving all rights to subpoena or to use Kelly M. Lewis, Ph.D. (GlobeCoRe, Inc.) or any GlobeCoRe, Inc. therapeutic staff in any current and/or future court litigations or actions.

If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.
In the event that Kelly M. Lewis, Ph.D. (GlobeCoRe, Inc.) does become involved in legal proceedings involving a client or clients, an initial payment of $3000 is expected at the beginning of any related services. There will be an additional charge of $300 per hour for any work pertaining to court litigations/actions (paperwork, phone calls, appearances, etc.). This payment will be billed to the client and is expected to be paid on a weekly basis; any statements left unpaid will automatically forfeit further interaction and will be sent to collections.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. I request that payment be made before your session begins. If you are using insurance benefits, GlobeCoRe will file insurance claims for you, and will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. Please be aware that most insurance agreements require you to authorize GlobeCoRe to provide a clinical diagnosis, and sometimes additional clinical information such as treatment plans or summaries, or in rare cases, a copy of the entire record. This information will become part of the insurance company's files, and in all likelihood, some of it will be computerized. It is best to discuss all the information about your insurance coverage with your Therapist, so you can decide what can be accomplished within the parameters of the benefits available to you and what will happen if the insurance benefits run out before you are ready to end treatment. It is important to remember that you always have the right to pay for counseling services yourself if you prefer to avoid involving your insurer. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, I expect full payment at the time of service, and I will provide you with a statement for services rendered.

EMERGENCIES: You may encounter a personal emergency that will require prompt attention. In this event, please contact our GlobeCoRe office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, our number will be given on my voice mail system. Please utilize this number in the event of a serious crisis, and we will call you back as soon as possible. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your therapist is out of town, you will be advised and given the name and phone number of a mental health facility.

CONFIDENTIALITY: As licensed psychologists/psychotherapist (in training), we will follow all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Telephone Number
_____	_____
_____	_____

TECHNOLOGY STATEMENT: In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains professional. Therefore, we have developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. However, we realize that most people have and utilize a cell phone. We may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with the GlobeCoRe office manager or your therapist.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with the GlobeCoRe office manager or your therapist. **However, please know that it is our policy to utilize these means of communication strictly for brief topics such as appointment confirmations.** Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. **You also need to know that we are required to keep a copy of all emails and texts as part of the client's clinical record.**

Facebook, LinkedIn, Instagram, Pinterest, Etc: It is our policy not to accept requests from any current or former client on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality. Our therapist and GlobeCoRe, Inc. have a professional/business Facebook page, a Twitter account and are on LinkedIn, etc. You are welcome to follow us on any of these pages. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to your therapist or to GlobeCoRe. If you would like to follow us on any of these media, you might want to consider using an alias to keep your connection with us confidential, but that is entirely your decision.

Google, etc.: It is our policy not to search for our clients or collateral participants on Google or any other search engine. I respect your privacy and make it a policy to allow you to share information about yourself with me as you feel appropriate. If there is content on the Internet that you would like to share with us for therapeutic reasons, please print this material out and bring it to your session.

Twitter & Blogs: We may post psychology news on Twitter or write an entry on a blog. If you have an interest in following either of these, please let us know so that we may discuss any potential implications to our relationship.

Once again, maintaining your confidentiality is a priority. We would recommend using an RSS feed or locked Twitter list, which would eliminate you having a public link to our content.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that we are open to any feelings or thoughts you have about these and other modalities of communication.

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Dr. Lewis (GlobeCoRe) will not render services to your child until she has received and reviewed a copy of the most recent applicable court order.
My signature below shows that I understand and agree with all of the statements above and on the preceding pages.

_____ _____
Signature – Client/Parent Date

_____ _____
Signature – Spouse/Partner/Parent Date

_____ _____
Therapist Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____ _____
Client/Parent Date

I authorize the payment of medical benefits to the provider of services.

_____ _____
Client/Parent Date

Cancellation Policy

Because there is often a waiting list of clients seeking appointments, at least a 24 hour notice must be given prior to cancelling an appointment. When an appointment slot cannot be filled, it costs the therapist from $125-$200. Insurance companies do not pay for missed appointments. ***You will be charged the full session fee and your signature below shows your agreement to pay the full session fee for missing an appointment or cancelling with less than 24 hours notice***.

_____ _____

Signature – Client/Spouse/Parent Date