Meghan McDonald, LPC
3225 Shallowford Rd.
Bld. 800 Suite 800
Marietta, GA 30062
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Today's Date:_____/_____/_____

CLIENT INFORMATION SHEET

Name _____ Date of birth _____/_____/_____ Age_____

Client Social Security #: _____Sex: Male/ Female Race/Ethnicity (optional) _____

Marital Status: Single Married Separated Divorced

Address _____

City/State/Zip _____ Home Phone _____

Email Address_____ Cell/Work Phone _____

Occupation _____Employers Name: _____

Name of your Primary Care Physician _____

PCP Phone: _____ PCP Fax_____

Referred By: _____

If Client is under age 18 Please provide the Name of Parent/Legal Guardian Bringing Child to Appointment:

Other people living in the home:

Name Age Relationship to Client

_____
_____
_____
_____

Emergency Contact: _____ Relationship_____

Complete Address: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Spouse's Name (If not Emergency Contact): _____Home Phone: _____Work Phone: _____Cell Phone:_____

PATIENT SELF REPORT

Patient Name: _____Age:_____ Date: _____

Name of person completing this form (if not patient):
_____

1. Briefly describe the problem which brought you here today._____

_____

_____

2. Check any issues you are having difficulty with.

ADHD	**Depression**	**Anxiety**	**Relationship**
hyperactive	sad	excessive worry	marital/significant other
impulsive	sleep problems	panic attacks	parenting
under achievement	neg. thinking	irrational fear	difficulty with friends
non-compliant	poor concentration	obsessions	work/school problems
inattentive	hopeless/worthless	social isolation	personal growth
poor concentration	mood swings	phobias	grief/loss
disorganized	guilt	compulsive	bullying/teasing

Anger	**Addictions**	**Abuse**	**Other**
short-fused	alcohol	physical	agitated
temp. tantrums	drugs	emotional	mania
impulse control	gambling	domestic violence	paranoia
violent/assaultive	relationships/sex	rape	delusions
runaway risk	eating disorders	sexual	tics/tourette's
fighting	cyber/internet	dissociative	cutting behavior
irritable	spending		appetite changes
oppositional			nightmares/flashbacks
			eating disorders
			pregnancy loss/abortion

Please explain any of the checked concerns:

_____
_____
_____

3. Are you now or have you ever had thoughts of hurting yourself

or someone else? yes no

Please Explain:_____

_____

Past Treatment **Therapist Comments**

4. Have you ever been treated for psychiatric, substance abuse, emotional, or behavioral

problems in the past? yes no

5. If yes, when, where, and with whom? _____

Inpatient_____ Outpatient _____

counselor psychologist psychiatrist substance abuse counselor

6. Did you find past treatment helpful? yes no

if yes, how'? _____

if no, why not? _____

7. Please list any medications given: _____

_____

8. Are you currently under the care of a psychiatrist or therapist for your current

problem? yes no

9. Are you currently taking any medications for psychiatric problems? yes no

If yes, please list: _____

_____

Medical Problems

10. Do you have any current medical problems? yes no

If yes, please list: _____

11. When was the last time you were seen by a doctor? _____

12. Would you like for us to communicate your information to your medical doctor? yes no

Therapist Comments

13. Are you currently taking medication for medical problems? yes no

lf yes, please list medication, dosage, and purpose: _____

_____

14. Do you have any allergies and/or medication allergies? yes no

If yes, please list: _____

15. Do you have a history of head injury, seizures or loss of consciousness? yes no

Please explain: _____

16. (Women only) Are you pregnant? yes no

History of miscarriages or issues conceiving? yes no

Please Explain: _____

17. Do you have pain management issues? yes no

Please Explain: _____

Substance Abuse

18. Have you been treated for drug, alcohol abuse, or other addictions (food, gambling, sex)? yes no

Please Explain:_____

19. Do you currently attend support groups? yes no

Which groups? _____

20. Circle the following you have used in the past 30 days: tobacco, alcohol, rnarijuar1a, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, amphetamines/speed, methadone, LSD, PCP, ecstasy, inhalants.

21. Have you experienced withdrawal symptoms? yes no

If yes, circle all which apply: withdrawal, headaches, nausea, vomiting, tremors, seeing things, hearing things.

22. Have you ever been arrested for a DUI? yes no

Please Explain: _____

Legal Issues

23. Do you have current legal problems? yes no

If yes, describe: _____

_____

24. Are you currently on probation/parole? yes no

25. Do you haves DFACS worker? yes no

Employment/Education

26. Circle current employment status: full time, part time, unemployed, homemaker, student, disabled, retired.

27. Are you currently on leave from work

or seeking medical leave/disability? yes no

lf yes, do have paperwork that needs to be completed? yes no

lf yes, please give clinician paperwork at beginning of session!

28. Circle educational background:. current student, did not complete high school, graduated high school, GED, some college, graduated college, advanced degree.

29. Did you experience difficulties in school? yes no

Family/Relationships **Therapist Comments**

30. Please list anyone who lives in your home, his/her age, and relationship,

_____

_____

31. Does anyone in your immediate family have-psychiatric, emotional,

substance abuse, or behavioral problems? yes no

32. ls your immediate family supportive of you seeking treatment? yes no

33. Does anyone in your extended family have psychiatric, emotional,

substance abuse, or behavioral problems? yes no

lf yes, please describe: _____

34. Do you have any domestic violence history or current issues? yes no

35. Do you have any history of sexual and/or physical abuse? yes no

36. Is your support network (Circle one) Good? Fair? Poor?

(i.e. friends, family, neighbors, religious organizations)

Please list: _____

37. What are your hobbies/interests? _____

_____

38. Do you have difficulties or concerns about how you get

along with other people? yes no

39. Are you having difficulties with spiritual or religious matters? yes no

40. Do you have any sexual orientation/gender issues or concerns? yes no

Treatment Access/Mobility

41. Are there any financial concerns that would affect your ability

to access treatment'? yes no

42. Do you have access to transportation? yes no

43. Do you have any disabilities, special needs, or other restrictions

that may impact your treatment or access to treatment? yes no

44. Based on the information you provided in this self report, what would you

like to see changed? _____

_____

_____

45. In your opinion, what could block or prevent that change? _____

_____

_____

Patient (or person completing this form) signature Date

_____ _____

Clinician Signature/Credentials Date

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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 _____

Emergency Contact Name: _____Phone: _____

Emergency Contact Email: _____

We have an automatic system that sends emails, texts, and voice messages. We also may contact you directly via text, email, cell phone, or video chat. Do we have your permission to correspond with you by these methods? Please note that some of these modes of communication are not secure. We will maintain as much confidentiality as we can regarding your private information (encryption, HIPAA compliant email, etc…)

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? _____

Billing and Financial Information Form

We truly appreciate you choosing to come to us 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. Verification of benefits from your insurance carrier does not guarantee payment from them. If by some chance your insurance does not pay for your services here at Safe Harbor Counseling Services, you will be responsible for all fees. Our *Patient Care Specialists* will gladly answer any questions you may have about our services, your mental health benefits, and any questions you have about our policies and procedures.

Patient's name: _____ Birthdate: _____Soc. Sec. #: _____ Address:

_____Home phone: _____

INSURANCE:

Primary Insurance Co: _____ Insured's Name: _____

Date of Birth: _____ Insured's SS#: _____

Member ID No. _____Group No. _____

Information Found on the Back of the Card:

Claim Address: _____ Provider Phone: _____

(If the patient is a dependent)

Primary Subscriber on Insurance Name: _____

Birthdate: _____Employer: _____

Work phone: _____

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

Soc. Sec. #: _____Occupation: _____ Employer: _____

Work phone: _____

PLEASE NOTE: IF YOU MISS AN APPOINTMENT OR DO NOT CANCEL 48 HRS IN ADVANCE, YOU WILL ASSESSED A $75.00 MISSED APPOINTMENT FEE.

BILLING AND PAYMENTS: You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, we will have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim. Any returned checks or declined credit cards will result in a $25 fee that will need to be paid before your next appointment.

INSURANCE REIMBURSEMENT: In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. Our practice policy is that every client has a valid credit card on file with us. We use a secure system that is compliant with The Payment Card Industry Data Security Standard (PCI-DSS).

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): _____

Authorized Amount to Charge Card: _____

I, authorize *Meghan McDonald of Safe Harbor Counseling Services* 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 of $75 should I miss my appointment or not give a full 48 hours' notice of cancellation. This authorization may be revoked upon providing a written statement.

Print Name: _____ **Date:** _____

Sign Name: _____

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Informed Consent for Treatment

(As required by HIPAA and the State of Georgia) this document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), which is a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that I provide you with a Georgia Notice Form about the use and disclosure of your Protected Health Information for treatment, payment and health care operations. A copy will be provided if requested. The Georgia Notice Form explains the HIPAA law and its application to your personal health information in detail. The law also requires that I obtain your signature acknowledging that I have provided you with this information at the end of your first session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session.
When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES:

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part and in order for the therapy to be most successful; you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.
But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our next session may include.

You should evaluate this information along with your own opinion of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If needed, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

SESSIONS:

Individual sessions are customarily 45-50 minutes; including time spent scheduling appointments and paying fees. Longer or more frequent sessions can be arranged as necessary. Please note: If you miss an appointment or do not cancel 48 hours in advance, you will be assessed a $75.00 missed appointment fee. It is important to note that insurance companies do not provide reimbursement for cancelled sessions so the total cost of the session is your responsibility.

PROFESSIONAL FEES:

My hourly fee is $125.00 an hour for individual Psychotherapy sessions, $150 an hour for Pre-Marital Counseling, $150.00 for couples/marriage counseling, $50 per person for group sessions and $150.00 per hour for Initial Assessment. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. I do not testify in court, but if the situation arises and it cannot be avoided because of the difficulty of legal involvement; I charge $200 per hour for preparation and $250 per hour for attendance at any legal proceeding, including travel time. There is $500.00 retainer fee which will be credited towards your balance. There is a $100.00 fee for filling out disability or social security forms.

CONTACTING ME:

I have a 24-hour confidential voice mailbox at (770)284-8992, at which you may leave a voice message. We also accept faxes on our number (770) 284-8992. Our patient care specialist will check for messages regularly and will return calls as promptly as possible. I will make every effort to return your call on the same day you make it, with the exception of Sundays and holidays. If it is an emergency, please call 911, go to the nearest emergency room, or call the Georgia Crisis line at 1-800-715-4225. If I am unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY:

The law protects the privacy of all communications between a client and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. Other situations require only that you provide written, advance consent. Your signature on this agreement provides written advance consent for activities such as those outlined below.

There are some situations where I am permitted or required to disclose information without either your consent or your written Authorization: · If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychotherapist-client

privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. As a rule, I do not enter into any court proceedings unless court ordered. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them. · If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself. · If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills. There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about your treatment. These situations are unusual in my practice. · If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Resources. Once such a report is filed, I may be required to provide additional information. · If I 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, I must report to an agency designated by the Department of Human Resources. Once such a report is filed, I may be required to provide additional information. · If I determine that a client presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

CONFIDENTIALITY OF ELECTRONIC COMMUNICATION:

Electronic communication is not completely confidential. By signing this agreement, you are authorizing electronic communication via text, fax, cell phone, video conferencing or email. You also understand that email and texting should be used for administrative purposes only. If you need help outside of business hours or if an emergency arises please call 911 or go to your nearest emergency room. Please note that I am not available to conduct therapy via electronic means. I do offer counseling sessions via Vsee video chat, although a separate informed consent must be signed prior to those services. I will reply to all electronic communication within one business day.

THIRD PARTY COMMUNICATION:

I have contracted out for such services as administrative support, billing, and credit card processing. All companies that I contract with are required to sign a Business Associate Agreement where the contracted company agrees to maintain the same HIPAA compliance and confidentiality as Safe Harbor Counseling Services, LLC. By signing this agreement, you are agreeing to have your information given to these companies.

HIPAA NOTICE OF PRIVACY POLICIES:

By Signing below, you are agreeing that you have been given a copy of the HIPAA notice of privacy policies.

COUPLES AND FAMILY SESSIONS:

When conducting couples or family therapy, no secrets will be kept among the members present for therapy. Any communication by anyone involved in the sessions outside of the session will be shared among everyone involved in treatment.

TERMINATION:

Termination of therapy is an essential part of the therapeutic process. If you feel that you want to terminate your treatment, or be referred to another provider, please discuss this with your therapist in session. If your therapist feels that you are no longer a fit for therapy, they will give you the appropriate referrals and recommendations. It is advised that you don't quit therapy without a termination session. Clients charts will be closed after termination and will be kept for 7 years, unless you are a minor and they will be kept for 10 years, from the date of last contact. If you do not contact your therapist or come to therapy for 30 days your chart will be closed and you will be deemed an inactive client. Should you choose to come back to therapy your chart will be re-opened. Please note that re-opening your chart may require new paperwork to be completed.

PROFESSIONAL RELATIONSHIP:

Please note that the therapy relationship is one of a professional nature. As such I am not allowed to be connected to you on any social media (Facebook, Instagram, LinkedIn, etc.…). If we are at the same social engagement or in public, I am prohibited from approaching you due to maintenance of confidentiality. However, should you choose to approach me in public, please be aware that I cannot guarantee confidentiality. The professional relationship continues even when therapy has been terminated.

Please sign below to indicate that you have read the informed consent and are aware of all of the terms, risks and benefits of treatment.

Print name: _____ *Meghan McDonald, LPC*

Signature: _____ Date:_____

Date: _____