

Great Life Counseling Center

14275 Midway Rd., Ste. 260

Addison, TX 75001

GREATLIFECONSULTS.COM

~ Welcome ~

Please read and complete the forms of this Group packet. Please note any questions you have and discuss them with your group leaders prior to the first group session.

Packet Contents:

- 1. Demographic/Financial Responsibility Form**
- 2. Office Policies and Consent to Treatment Form**
- 3. Group Confidentiality Agreement**
- 4. Intake Questionnaire**

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DEMOGRAPHIC/FINANCIAL RESPONSIBILITY FORM

Name: _____ DOB: ____/____/____ Age: _____
Home Phone: _____ Cell: _____ E-mail: _____
I authorize text messages to my cell phone and messages to the contact numbers & email provided YES NO
Residential Address: _____ City: _____ Zip: _____
Employer: _____ Position/Type of Work: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Referred by: Insurance Company Internet Search Physician Friend Other: _____

Insurance information
Name of Insured (Policy holder): _____ Date of Birth of Insured: ____/____/____
Insurance Carrier: _____ Insurance Phone#: _____ Co-pay \$ _____
Deductible: _____ Deductible Met: _____ Pays at: _____
Policy/ ID#: _____ Group#: _____ Employer: _____

FEES & PAYMENT:

- Payment for each group session is **\$35**. Great Life Counseling Center clinicians are currently out-of-network providers for all insurance companies, except Blue Cross Blue Shield PPO.
- If you would like to pay through BCBS, Great Life Counseling Center will bill your insurance company directly for services provided minus your copayment. Great Life Counseling Center may be required to release the required information about your care to your insurance provider including, but is not limited to, diagnosis codes, dates of service, treatment plans, and treatment progress.
- If your insurance company should deny payment or reimbursement, you remain ultimately responsible for any outstanding financial debt associated with services provided. Great Life Counseling Center reserves the right to email or mail a client an invoice and/or utilize a collection agency in efforts to address outstanding balances.
- Payment is due at the time services are rendered in the form of **cash, check, or charge**. All checks should be made out to **Great Life Counseling Center**. MasterCard, Visa, American Express, & Discover are accepted.

With my signature below, I acknowledge the statements above and accept financial responsibility for services rendered.

Client Signature: _____ **Date:** _____

A copy of this completed & signed document will be provided at your request.

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OFFICE POLICIES AND INFORMED CONSENT

Welcome and thank you for entrusting Great Life Counseling Center with your care! This document contains important information about our professional services, business practices, and it will serve as a therapeutic contract. Please read it carefully and jot down any questions you would like to discuss.

THE THERAPY PROCESS

There are many possible benefits of psychotherapy groups. These benefits include, but are not limited to, learning how to better understand how you relate to yourself and others, receiving social support, and gaining a sense of validation among peers. Sharing concerns, struggles, and possible solutions can help you to see that you are not alone and that others can benefit from your experiences. Group participants also have the potential benefit of receiving psychoeducational knowledge and skills that are aimed to increase psychological well-being and functioning. Group participants are not required to talk during group discussions, but the more participants share in these discussions, the more they are likely to benefit.

Although psychotherapy groups have many potential benefits, there are some inherent risks or challenges. Attending groups may involve the risk of recalling unpleasant events or discussing troubling or embarrassing issues. Consequently, people may experience feelings of discomfort or distress in reaction to topics discussed in group sessions. Additionally, although group leaders will not share client communications or information except under limited circumstances (see “Confidentially” and “Exceptions to Confidentiality”), an inherent risk with group discussions is the confidentiality of information disclosed. All group participants sign an agreement to hold information disclosed as confidential (see “Group Confidentially Agreement”). However, group leaders cannot promise that other group participants will maintain confidentiality.

EMERGENCY PROCEDURES/POLICIES:

- ❖ Telephone, text, & email consultations between group sessions are welcome. In fact, if participants know ahead of time that they will miss a session(s), they are encouraged to share this information with their group leaders. However, any contact outside of group sessions will be kept brief. Group participants are encouraged to consider individual psychotherapy or waiting until the next group session to discuss matters that will take more than 15 minutes to explore. **If out-of-group correspondence requires more than 15 minutes of the group leader’s time, charges for each 15-minute increment will incur (including the first 15 minutes).** Payment for such consultations is due at the start of the next group session or within 10 business days (whichever occurs first). On weekends and holidays, messages are checked less frequently. Calls, texts, & emails will generally be responded to within 24 hours or by the end of the next business day

- ❖ **Great Life Counseling Center’s contact number is *not* an emergency number. In the event of a mental health or medical crisis, please call 911 or one of the following crisis lines, which are available 24/7:**
 - Suicide & Crisis Center of North Dallas – **214-828-1000**
 - National Suicide Prevention Lifeline – **1-800-273-TALK**
 - National Domestic Violence Hotline – **1-800-799-SAFE**
 - National Sexual Assault Hotline – **1-800-656-HOPE**
 - If your crisis is due to a medical issue or medication, contact your physician or psychiatrist.

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CONFIDENTIALITY:

In most cases (see “Exceptions to Confidentiality” below) communications between client and psychologist will be held in strict confidence - unless client provides psychologist with written permission to release information about treatment or there is an imminent safety threat.

Protecting client privacy is a high priority for Great Life Counseling Center & its associates. Intake paperwork, group therapy notes, consultation notes, & reports are kept in a locked file cabinet in a locked room until they are typed or uploaded onto an accredited web-based electronic health records system, TherapyAppointment.com. Scheduling & file information on TherapyAppointment.com is protected with bank-level security, which includes the highest levels of data infrastructure, virus prevention, spam filtering, and encryption measures. Prior to being archived, encrypted records are kept on a secured flash drive so they are not saved on any computer. For additional information about your privacy rights & HIPAA, visit the website: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html>

EXCEPTIONS TO CONFIDENTIALITY

Safety Concerns

Psychologists & other mental health professionals are legally-mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse. Psychologists are may also break client confidentiality in an attempt to prevent a client from harming themselves or others.

Professional Consultation

In accordance with recommended best practices, Great Life Counseling Center clinicians regularly consult with each other and enjoy collaborating to provide the best care possible. These consultations may include the review of video recordings or just an exploration of different strategies for improving the likelihood of positive outcomes. However, identifying information is never shared with anyone outside of the clinical team and, after recordings or presentation materials have been reviewed by the Great Life Counseling Center team, they are immediately shredded or deleted (not to exceed 4 weeks following the date of the recording).

Electronic Communication, Videoconferencing, or Phone

Great Life Counseling Center is nearly paperless business and relies on different information technologies such as emails, text messages, phone calls, video conferences, fax, & an electronic medical record system to communicate, record, and store client information as well as transmit business transactions. Use of these technologies allows Great Life Counseling Center to serve your needs more efficiently and effectively and Great Life Counseling Center associates take reasonable steps to protect the privacy of its clients & minimize risk of any breach or errors in transmission. However, clients are required to acknowledge and accept the inherent risks of such technologies and electronic mechanisms (e.g., risk of information being erased or destroyed due to a malfunction or act of God; information intercepted and/or hacked by unauthorized parties; or information being erroneously transmitted to the wrong email, fax number, or phone number).

CLIENT ACKNOWLEDGEMENT OF POLICIES AND CONSENT TO TREATMENT:

- ❖ With my signature below, I acknowledge that I have had ample opportunity to review Great Life Counseling Center’s policies.
- ❖ My signature indicates that I understand & accept the stated policies and the risks noted herein.
- ❖ Finally, my signature indicates my willingness to abide by the terms of this agreement.

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Client signature _____ **Date** _____

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GROUP PARTICIPANT’S CONFIDENTIALITY AGREEMENT

Confidentiality, a trust of privacy or secrecy of communication and information, is unique in a group/workshop setting, and is the shared responsibility of all workshop/group members and facilitator(s). Group leaders will not disclose group participants’ communications or information except under limited circumstances (see “Confidentially” and “Exceptions to Confidentiality”). However, group leaders cannot promise that other group participants will maintain confidentiality. Thus, this agreement is an attempt to provide you and your fellow group participants with as much confidentiality protection as possible.

As a participant in Great Life Counseling Center’s _____ **Group**, I will not divulge any confidential information that comes to me through group discussions.

This includes:

- not discussing or releasing any identifiable information pertaining to a group participant with anyone not participating in this group, including family members, roommates, or significant others.
- not discussing any identifiable information pertaining to a group participant in a place where it can be overheard by anyone not directly involved with the group.

I understand that violation of these confidentiality principals could potentially result in my termination as a group participant. Additionally, breaching confidentiality may subject me to civil or criminal liability.

By my signature below, I indicate that I have read carefully and understand this agreement and that I agree to its terms and conditions.

Signature of Participant

_____ **Date** _____

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INTAKE QUESTIONNAIRE

NAME: _____

PRIMARY COMPLAINTS: What brought you into group therapy today? _____

EXPECTATIONS: What do you wish to change or accomplish as a result of group?

HISTORY OF TREATMENT: Have you been in therapy before? Yes No If yes, please note the when, name of clinician/agency, and primary issues addressed:

Reflecting on the last 6 months, please circle all that apply:

Frequently sad or depressed	Feeling restless or keyed up
Overwhelming worries	Restless unsatisfying sleep
Difficulty falling asleep or staying asleep	Muscle tension
Unable to concentrate	Mood Swings
Irritable and/or short temper	Decreased need for sleep (only need 3-4 hrs)
Significant change in weight	Feel more talkative than usual
Low energy level/fatigue	Excessive spending/shopping
Feeling excessive guilt or shame	Excessive gambling
Unable to relax	Easily distracted by unimportant things
Lack of appetite/increased appetite	Take too many risks
Loss of interest in activities/hobbies	Troubling thoughts about the past
Feeling hopeless	Nightmares
Feeling worthless	Exaggerated startle response
Difficulty motivating	Too neat and orderly
Withdrawn/isolating self	Repeating certain behaviors over and over
Cry easily/often	Easily upset or angered
Difficulty making a decision	Feeling different from most people
Difficulty finishing tasks	Shy around others
Thoughts to hurt self	Increasingly forgetful
Attempts to harm yourself	Strong fears
Thoughts to hurt others	Difficulty with work or school
Threats to hurt others	Use of painkillers and analgesics
Feeling ill/sick	Stomach aches/vomiting