

## **INFORMATION, AUTHORIZATION, CONSENT, & TREATMENT**

WELCOME to Northeast GA Counseling, (NEGC) and thank you for choosing our agency! You can expect to be treated with respect, warmth, and confidentiality by our staff and therapists. Our office staff are available 8:30 am to 3:00pm Monday thru Friday to assist with making or rescheduling appointments and answering questions. The following information is to help you further understand the therapeutic process and the collaborative relationship you have with your counselor.

### **First Appointment/Client Participation**

Your first appointment we will focus on “what brought you here.” Your counselor will gather information and establish a positive relationship in order to discuss the sensitive matters that are stressing you and your family. We believe through self awareness and self acceptance along with changes of behavior, our clients find more peace and better resolve to the problems in their lives. In order for that process to be successful, you, the client, must take an active role. Therapy is most effective when clients are fully honest, work between sessions, and refrain from alcohol or non prescription drug usage prior to the sessions. Some clients need only a few sessions to improve their situations, while others may need much longer treatment.

NEGC focuses on helping clients within our specialties and whom have the ability to resolve problems with our assistance. If after we meet on the first or subsequent sessions and feel we cannot assist you, we will offer you appropriate referrals. YOUR problem resolution is our top priority always.

Therapy is not always easy. Our job is to help you identify the problems, counterproductive patterns, and the role you play in your distress. Through a trusting relationship with your counselor, you gain support, education, and tools to change situations and patterns. We expect hard work for the best benefit and emphasize at each appointment how things are better, how to sustain changes, and/or how to increase the changes made.

### **Statement Regarding Ethics, Child Welfare, & Safety**

NEGC renders all services in a professional manner consistent with both American Counseling Association and National Association of Social Workers code of ethics. Should you have any concerns your therapist is not performing in an ethical manner, please let him or her know immediately. If further assistance is needed, please contact our director, Lisa Pope Campbell, LCSW at 770-271-5040.

In order for counseling to be effective, one must be open, honest, and self-reflective. We would like to guarantee results, however, that depends on your participation and motive. Your therapist will work with you to achieve the best results possible. Please know that changes made in therapy may affect other relationships in your life as well. For example, becoming more self aware may create more assertiveness which may not always be welcomed by others. Our therapists help you manage the ripples which may occur as a result of changes you implement. Also, you may feel worse at the beginning of therapy before you begin to feel better. Many times acknowledging problems and sensitive issues is new behavior and creates its own discomfort. However, discovering this discomfort is the beginning of

successful changes. You and your therapist can then develop strategies and coping skills to target your particular needs, providing help and relief.

## **COURT / Stipulation for Counseling**

When there is a possibility of litigation, (legal/court actions, separation/custody/divorce proceedings, disability applications, etc.), THERAPY BECOMES LESS EFFECTIVE. The tendency is to present oneself in a better light and/or highlight the negative attributes of another person or situation. Counseling cannot be as effective when this occurs. The gains from therapy are reduced significantly as client motives are slanted and often unclear. I (we) agree to waive all rights to subpoena and/or otherwise use NEGC records, files, or any part of the counseling process in any and all future litigation and/or court actions.

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client name (please print/ date)

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Client signature/date

## Communication

NEGC is an outpatient facility which means we are structured to serve clients who are reasonably safe. Our counselors are not available at all times. We will return calls and emails within 48 business hours, not on weekends and holidays. We work closely with local physicians and refer to them and/or a local psychiatric hospital when needed. For all emergency situations, we ask you to call 911 or go to a local psychiatric hospital.

## Technology/Media

It is vital that you know our voicemail is a non secure VOIP. Therefore, we encourage you to leave only basic information on our vm. All communication may not be completely secure including landlines, due to the possibility of hackers with special technology. Most people communicate with a cell phone as does NEGC. If this is a problem, please let us know. Please know that others who have access to your cell phone may know your calls, length of calls, etc.

TEXTING is also a non secure form of communication. We may use text messages in confirming appointments only. We DO NOT utilize texting and will not respond to a text for your protection in any other context than confirmation of appointments.

EMAIL is also a non secure form of communication, and therefore, we do not email other than scheduling information or responding to basic questions that are not personally identifiable information. We use non encrypted email and request non personal health information in your emails to NEGC.

SOCIAL MEDIA is non confidential; therefore, we do not accept friends or connections from any clients. NEGC does have a professional FB page, Linked In, Instagram & Twitter that you are welcome to follow if you are comfortable with others in the public being aware of your name attached to NEGC.

## Confidentiality

Your therapist will always keep everything you say to him or her confidential with a few exceptions: 1) You sign a release of information and request information to be given to another, 2) your therapist determines you are a danger to yourself or others, 3) you report information about the abuse of a child, an elderly person, or a disabled person who may require protection, or 4) a judge orders your therapist to disclose information. Your therapist's license does provide him/her with privileged communication. That means you have a right as a client to confidentiality with your therapist. The state of GA respects that right; however, should a judge overturn that right, we assure you we will do all we can to keep what you say confidential.

Your communications with your therapist will be kept in a clinical record which is your Protected Health Information (PHI). It is stored in a file cabinet in a locked business office for 6 months. If we have no contact with you after 6 months, it is stored appropriately. Ultimately after 7 years, the record will be shredded. Additionally, we use OfficeAlly to bill your insurance. Your PHI will be will be securely transferred electronically, and this billing company has signed a HIPAA Business Associate Agreement

ensuring they will maintain the confidentiality of your PHI in a HIPAA compatible secure format. Also, you will usually receive correspondence from your insurance company in the mail.

If you are using your insurance, please know we utilize a billing service who has access to your PHI. It is like having a third party in the room with your sensitive subjects. They reserve the right to review your records in order to justify the claim. The insurance requires we give you a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders. Clinically and ethically we must provide accurate coding. This information may be reported to a national medical information data bank. We cannot foresee how this diagnosis may impact your future in regard to disclosure on items such as life insurance applications, or other health insurance applications. It is for this reason, we keep our rates competitive and many clients bypass their insurance and pay out-of-pocket. This way, we are bound by confidentiality.

In addition, cell phones, texting, and email are not a secure means of assuring confidentiality. There is a possibility that someone could overhear or interrupt our conversations. Also, individuals may see who you talked to on a bill, how the call was initiated, etc. We will utilize email strictly for brief topics such as appointments and cancellations. Please do not bring up therapeutic content via email. Also, if you are in a crisis, do not rely on email as we may not see the email on a timely manner. If an after hours emergency, please go to your local ER or local Psychiatric facility.

If you sign an authorization to send your medical record information to an entity, we need to fax that information to the entity directly. Again, fax machines may not be a secure form of transmitting information.

## **Cost & Cancellation Policy**

Your sessions are 45-50 minutes in length, as your insurance companies benefits mandate. We strive to be on time, but be assured we will meet with you the 45-50 minute length unless you have otherwise negotiated a different amount of time.

Sessions are \$130 for the initial assessment per 50 minutes and \$100 per 50 minute sessions thereafter. Telemental health:, telephone, Skype, or Facetime) are not reimbursed by your insurance but may be accepted at your request for your convenience depending on the details of your situation.

If at any time court is requested and authorization is received, our fees are \$350 per hour including preparation and travel time.

Cash, personal checks, visa, MC, and discover are accepted as payment. There is a \$35 fee for returned checks. We will provide you with a receipt of payment.

Our therapists try diligently to schedule appointments to accommodate work and school schedules. Each therapist offers different availability. We offer both evening and Saturday hours trying to meet the needs of our clients. We also reserve 50 minutes for your appointment. We strongly request 48 hour notice in canceling your appointment so we may serve others who are on a waiting list. However, we charge \$75 for appointments not canceled WITHIN 24 HOURS or MISSED APPOINTMENTS. . These are

not reimbursable by your insurance company. You will be unable to reschedule an evening or Saturday appointment with any outstanding missed appointment balance. Also, new clients will be unable to schedule a second appointment if they missed their initial appointment until the \$75 missed fee is paid in full. We will bill your insurance as a courtesy to you and accept your deductibles and copayments at the beginning of each session. However, YOU ARE RESPONSIBLE FOR FEES FOR SERVICES PROVIDED THAT MAY NOT BE COVERED BY YOUR INSURANCE. Further, if your insurance company is slow( in excess of 2 months) or does not pay, we will expect your payment in full. Also, it is your responsibility to find out your insurance company's policies and requirements; however, we will verify them as well as a courtesy to you.

### **In Case of Emergency**

**If you have a mental health emergency, we encourage you to contact your physician or call 911. You may also call one of the local hospitals like Laurelwood, Summitridge, Peachford, Ridgeview, or Lakeview as they have 24 hour coverage. You may also phone the National Suicide hotline at 1-800-273-talk(8255) .**

**We are REALLY glad you have chosen NEGC for your counseling needs, and we sincerely look forward to helping you resolve your problems and have relief.**

**Please print and sign your name below, indicating you have read and understand ALL THE INFORMATION provided, agree to the policies of NEGC, and are AUTHORIZING us to begin treatment with you.**

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Client name (please print)/ date

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Client signature

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Parent or legal guardian's signature/date

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Name: \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_  
 City: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_ WA#: (\_\_\_\_) \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed  Living together as a couple

Name of Legal Guardian (if client is under 18): \_\_\_\_\_ Legal Guardian's Relationship to Client: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Emergency Contact Phone #: (\_\_\_\_) \_\_\_\_\_

How did you hear about Northeast Georgia Counseling? \_\_\_\_\_

Have you had any prior counseling, psychological or psychiatric treatment?  Yes  No

If Yes When? \_\_\_\_\_ With Whom? \_\_\_\_\_

Who is your Primary Care Physician (PCP)? \_\_\_\_\_

PCP Phone #: (\_\_\_\_) \_\_\_\_\_

Are you currently taking any medications?  Yes  No

If "Yes", please list all medications relevant to therapy: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Do you have any medical conditions relevant to therapy?  Yes  No

If "Yes" Please list them: \_\_\_\_\_

\_\_\_\_\_

What is the primary reason you are seeking counseling? \_\_\_\_\_

How long has this problem persisted? \_\_\_\_\_

What would you like to get out of counseling? \_\_\_\_\_

I am currently experiencing:	I have a history of:	Problem Categories *X all that apply - circle primary
_____	_____	1. Alcohol
_____	_____	2. Drugs (specify) _____
_____	_____	3. Emotional Problems
_____	_____	4. Marital Problems
_____	_____	5. Family
_____	_____	6. Physical Health (specify) _____
_____	_____	7. Another's alcohol or drug
_____	_____	8. Another's emotional health
_____	_____	9. Legal/Financial Problems
_____	_____	10. Other (specify) _____

Level of severity (How much do these problems bother you?)  
 Minimal \_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_ Extreme \_\_\_\_\_

## Client Insurance and Billing Information

(Please present insurance card to be copied by provider)

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### Client(s) Information (person / persons we will be seeing)

Client Name(s) \_\_\_\_\_ DOB: \_\_\_\_\_  
(individual or couples names)

\_\_\_\_\_ DOB: \_\_\_\_\_

Client Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Client Social Security Number: \_\_\_\_\_ Wk/Cell Phone #: \_\_\_\_\_

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### PRIMARY INSURANCE INFORMATION (person that holds the insurance policy)

Name of Insured: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_

Insured's Address \_\_\_\_\_ Home Phone #: \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Name of Insured's Employer \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Relationship to Client (please circle one):    Self    Spouse    Parent    Other

Insured's Social Security number: \_\_\_\_\_ Insurance Policy #: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Mental Health Phone #: \_\_\_\_\_ Authorization #: \_\_\_\_\_

\_\_\_\_\_ Please Note: Insurance companies often require clients to obtain preauthorization before the first appointment. You are responsible for obtaining the initial authorization. Before you are seen for the first appointment we must have the authorization information (i.e. authorization number and/or letter) given to you by the insurance company as well as a copy of your insurance card. We suggest that you confirm your outpatient mental/behavioral health benefits (deductible, co-pay, which providers in our office are covered, etc.) before arriving for your first appointment.

\_\_\_\_\_ I have read and agree to all payment and policies of NEGAC. I acknowledge that I am responsible for all charges whether or not insurance pays. I hereby assign all medical benefits to NEGAC and acknowledge that a photo copy of this assignment is valid as original. **I understand that insurance companies do NOT pay for missed appointments.**

\_\_\_\_\_ I authorize NEGAC to release confidential information regarding my treatment and diagnosis to my insurance company or managed card program.

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Patient Signature (or Legal Guardian)

Date

## Client Text Messaging Consent Form

To help clients remember their mental health appointment, and to reduce the number of missed appointments, we have introduced a new system. Clients can now be sent an appointment reminder by text message to a mobile phone.

If you wish to be reminded about your appointment by text message, please complete the following information:

I understand that my telephone number will not be used for any other reason. I also understand that I have the option to stop reminders by text message at any time.

I authorize Northeast GA Counseling to remind me by text message of all future appointments.

Name: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_