CLIENT INFORMED CONSENT FORM

I want to make your couples therapy experience as comfortable and productive as possible. Your first meeting with me will be an "intake Interview". The purpose of the intake interview is to help you clarify your couples concerns and, if needed, discuss any additional services that might be helpful to you.

Completion of this intake packet will help you and me in planning a positive course of action. Please be as honest and forthcoming as you can when completing the forms so I can provide you with the best clinical guidance and support possible. Be advised that both members of the couple will need to complete the initial paperwork.

Statement of Confidentiality

Clients often raise questions about the privacy of what is discussed in counseling. All clinicians adhere to very strict confidentiality standards. Client information is managed using procedures designed to protect the privacy and security of personal data. Counseling records are strictly confidential, except in life threatening situations, cases of suspected child or elder abuse, or when release is otherwise required by law. In order to provide you the best possible services, I may consult with other mental health professionals.

In order to protect your right to confidentiality, your written authorization is required if you want us to provide information about your counseling to another person or agency. Some licensing boards and various federal agencies may require information regarding your use of counseling services prior to taking licensing exams or being employed. If you have any questions, you may ask me.

Due to couples work involving two people, the following information is important to clarify at the beginning of therapy. In order for counseling information to be released, both members of the couples must provide their written authorization. Since the couple is the client, one member's desire to have information released is not sufficient. Secondly, if we decide that some individual sessions may help the process of couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy. Therefore, be advised that this information will be discussed in our joint sessions.

Please sign below to indicate that you have read the above statement regarding records, confidentiality, and clinical services.

_____ _____

Client Signature Date

Client Responsibility Regarding Appointments and Payment

The counseling process involves responsibility and commitment on the part of the clinician and client. You will receive the most benefit from counseling if you attend your sessions regularly and participate actively in the counseling process. Please arrive on time for your appointments and make arrangements to stay for the duration of the session. This practice serves the greater Athens community, and there are always other clients waiting for services. For these reasons, I request that you take responsibility for the following:

- Payment for counseling sessions is expected at the beginning of each session.
- Cash or check are acceptable methods of payment.
- For checks that bounce, full payment for counseling session(s) and a $25 fee will be charged.
- Any uncollected balance may be turned over to a collection agency.
- Phone calls lasting longer than 5 minutes will be charged at the prorated amount of a session. This does not include calls solely for the purpose of scheduling.

Please initial below that you have read and understand your responsibility regarding appointments/payment

_____*(Initials)*

Cancellation Policy

If you need to cancel a scheduled appointment, please do so at least 24 hours in advance. This allows me to offer that hour to someone else. I recognize that life happens and therefore, **one** emergency cancellation (without 24 hours notice) is accepted per calendar year. After your one emergency cancellation is used, ALL future cancellations will be billed if insufficient notice is given, even if it's an emergency. If you do not show and do not cancel a scheduled appointment, you will be charged a full session fee for that time. Insurance companies will not reimburse for missed sessions so, unfortunately, this means you will be billed my full fee without a potential for reimbursement.

Please initial below that you have read and understand your responsibility regarding cancellation policy

_____*(Initials)*

In Case of Emergency

If you are experiencing a psychological emergency, you may use my emergency paging system by calling (678) 677-4851 and leaving your name and phone number and indicating that it is an emergency. You must leave an actual message or I will not be paged. Please reserve paging me for emergencies only. If it is during business hours and I do not call you back immediately, you can assume I am in session and have not yet retrieved your message. If you can wait, I check my pager between sessions and will call you then. If you cannot wait, or if I have been unable to return your call within an hour for some unforeseen reason, call your county's local mental health clinic whose number you can get by calling 411 or dialing 911. You can also do any of the following:

- Call the emergency crisis line at 1-800-715-4225
- Call Athens Regional Medical Center at (706) 475-7000
- St. Mary's Hospital at (706) 389-3000
- Call 911
- Go to your nearest emergency room

Please initial below that you have read and understand your responsibility regarding emergency procedures.

_____***(Initials)***

In Case of Emergency Contact (Please Circle the Number Below to Attempt First)

Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

We will only contact this person in case of a life threatening emergency. Please sign here to indicate that we have your permission: _____

Referral Follow Up

How did you hear about our services? _____

May we have your permission to thanks them for the referral? _____ Yes _____ No

Compliance with HIPPA Rules and Regulations

The following policies and practices are designed to protect the privacy of your health information. In order to utilize insurance for the purpose of receiving mental health services, I will need to disclose protected health care information in following circumstances:

- Benefits verification
- Attaining authorization for treatment
- Providing treatment plans and progress to begin and maintain treatment
- Information required to secure payment for services
- Coordination of healthcare operations (ensuring your specific insurance benefits are accessed and utilized properly)

Situations where information needs to be released and is not covered by the circumstances above (with the exceptions of mandatory reporting in cases of danger to self, danger to others, or court mandate) will only be done after securing written permission to release information. An explanation of the purpose of releasing the information will also be provided prior to release. Lastly, every effort will be made to keep the sharing of protected health information to a minimum.

Please initial below that you have read and understand the HIPPA rules and regulations and your responsibility associated with HIPPA compliance.

_____***(Initials)***

Consent to Couples Therapy

I have read and discussed the HIPPA rules and regulations, confidentiality statement and the office policies and procedures required to engage in couples therapy. I am willingly consenting to treatment with Dr. Case-Simonson under the parameters provided in the client informed consent and understand that I may withdraw my consent at any time and terminate services.

_____ _____

Signature Date

GENERAL INFORMATION

Last Name First Middle

Mailing Address

City State Zip Code

Phone (Home) Phone (Cell) Phone (Work)

May I leave a discreet message?

Home Phone: Yes ❑ No ❑ Cell Phone: Yes ❑ No ❑ Work Phone: Yes ❑ No ❑

Data of Birth _____ Age _____

Gender: _____ Male _____ Female _____ Transgender ____ Genderqueer ___ Other

Sexual Orientation: ___ Gay ___ Lesbian ___ Bisexual ___ Heterosexual ___ Asexual __ Other

Relationship Status:

❑ single ❑ partnered ❑ married ❑ divorced ❑ separated ❑ widow ❑ other _____

How long has this been your current relationship status? _____

Racial Background

❑ African Descent/Black ❑ American Indian ❑ Asian ❑Hispanic/Latino/a

❑ Caucasian/White ❑ Biracial/Multiracial (please specify) _____

Ethnic Cultural Background:

Nationality or Combination of Nationalities: _____

Professional Status (check all that apply):

❑ employed ❑ underemployed ❑ unemployed ❑ student ❑ homemaker ❑ retired ❑ other

Professional Title (current or past): _____

Professional Place (i.e. employer, school, home, etc.) _____

How long has this been your professional status? _____

Level of professional satisfaction: ❑very high ❑ high ❑ average ❑ low ❑ very low

PRESENTING ISSUES AS A COUPLE

Please *rank* (1 = Most Important) your top five presenting issues. *Check* all others that apply.

	Fair Fighting/Conflict		Sexual Intimacy Issues		Communication
	Assertiveness		Parenting Issues		Finances/Money
	Managing Family Relationships		Issues Associated with Household Management		Religious/Spiritual Differences
	Alcohol/Substance Abuse		Relationship Violence		Pregnancy/Abortion Issues
	Differences in Family Culture/Background		Physical Assault		Stalking
	Religious/Spiritual Matters		Alcohol/Substance Abuse		Physical Health Problems
	Loss/Death of Significant Person		Eating Problems/ Body Image Issues		Personal Growth/ Development
	HIV+/ AIDS Issues		Identity Confusion		Childhood Abuse (sexual, (physical or emotional)
	Men's Issues		Pregnancy/Abortion		Other:

PRESENTING ISSUES AS AN INDIVIDUAL

Please *rank* (1 = Most Important) your top five presenting issues. *Check* all others that apply.

	Career/Vocation		Oppression/Discrimination		Relationship Issues
	Stress/Anxiety		Depression		Finances/Money
	Self-Esteem/Confidence		Self-Injurious behavior (e.g., cutting)		Legal/Judicial Problems
	Family Relationships		Sexual Assault/Rape		Identity Confusion
	Pregnancy/Abortion		Physical Assault		Stalking
	Religious/Spiritual Matters		Childhood Abuse-sexual, physical or emotional		Physical Health Problems
	Loss/Death of Significant Person		Eating Problems/ Body Image Issues		Personal Growth/ Development
	HIV+/ AIDS Issues		Identity Confusion		Other:

PRESENTING ISSUES AS A COUPLE

Briefly describe your top 5 concerns/issues. Include a description of:
(1) symptoms associated with each concern (i.e. fighting, withdrawing from partner) and
(2) how disruptive each issue is to your relationship

PRESENTING ISSUES AS AN INDIVIDUAL

Briefly describe your top 5 concerns/issues. Include a description of:
(1) symptoms associated with each concern (i.e. crying, isolating, etc.) and
(2) how disruptive each issue is to your life and to your psychological well-being.

CLIENT BACKGROUND INFORMATION

Family (including family of origin and current family as applicable)

Name	Relation to You	Age	Education/Occupation	How close do feel towards them?

Family History-Does any member of your immediate *or* extended family suffer from the following?

❑ Depression ❑ Bipolar Disorder ❑ General or Social Anxiety ❑ Phobias/Panic Attacks

❑ Suicidal Thoughts, Attempt(s) or Completion ❑ Delusions ❑ Auditory/Visual Hallucinations

Addiction: ❑ Alcohol ❑ Drugs ❑ Gambling ❑ Spending $ ❑ Eating ❑ Sex/Pornography

❑ Hypothyroidism ❑ Hypertension ❑ Other _____

In the space below, please identify the family member(s) and briefly describe the problem(s)

_____

_____

_____

Medications- *Include medications taken for physical problems, psychological problems, and birth control*

Current Medication	Dosage/Frequency	Purpose	Prescribing Physician	Length of Use

Weekly Alcohol/Drug Usage (If Applicable)

Typical Number of Standard Drinks: _____ High Number of Standard Drinks: _____

Drug Used: _____ Typical Amount Used: _____

Drug Used: _____ Typical Amount Used: _____

Drug Used: _____ Typical Amount Used: _____

Previous Therapy (If Applicable)

Name of Previous Therapist: _____ Approximate Number of Sessions: _____

Therapy Goal(s): _____

Helpful Aspects of Therapy: _____

Unhelpful Aspects of Therapy: _____

Reason(s) for Ending Therapy: _____

Name of Previous Therapist: _____ Approximate Number of Sessions: _____

Therapy Goal(s): _____

Helpful Aspects of Therapy: _____

Unhelpful Aspects of Therapy: _____

Reason(s) for Ending Therapy: _____

Psychological Hospitalizations (If Applicable)

Have you ever been hospitalized for psychological reasons? ❑ Yes ❑ No

Have you seriously considered or attempted suicide during your lifetime? ❑ Yes ❑ No

If you answered yes to either question above, please provide the following:

(1) place(s) of hospitalizations (2) dates of hospitalization (length of stay)

(3) events leading to hospitalization (4) psychological diagnoses/medications used

(5) any additional information associated with previous hospitalizations

_____

_____

_____

_____