Counseling for Hope and Healing, LLC

INTAKE FORM

Date: _____

Client's Last Name: _____First Name: _____Middle Initial: _____

Date of Birth: _____ Age: _____ ( ) Male ( ) Female ( ) Married ( ) Single ( ) Widowed ( ) Divorced ( ) Partnered

Religious/denominational preference: _____Racial/Ethnic Identity: _____

Address: _____ City: _____ State:_____ Zip: _____

Home Phone: _____ OK to leave message? Y / N Email Address: _____ OK to email? Y / N

Cell Phone: _____ OK to leave voice message? Y / N OK to text message? Y / N

Referred by: _____ May we thank them? ( ) Yes ( ) No

Name of Employer: _____

Person to notify in case of emergency: Name: _____ Phone # _____

PAYMENT INFORMATION:

Payment is expected at the time of service. Payment is by credit or debit card (Mastercard, Visa, Discover, American Express.)

( ) I am responsible for all charges due to being a self-pay client. The fee is $110 per session.

Signature: _____ Date: _____

( ) I am over age 65 and agree to pay the Senior Discount rate of $75 per session.

Signature: _____ Date: _____

What concerns have caused you to seek counseling at this time? _____

What would you like to see happen as a result of counseling? _____

Please CHECK all that apply and CIRCLE the main problem:

Difficulty with:	Now	Past	Difficulty with:	Now	Past	Difficulty with:	Now	Past
Suicidal Thoughts			Homicidal Thoughts			Hallucinations		
Physical Abuse			Sexual Abuse			Domestic Violence		
Self-mutilations			Depression			Mood Changes		
Anxiety			Panic			Friends		
Alcohol Abuse			Substance Abuse			Other Addiction (specify)		
Anger			Irritability			Concentration		
Fears			Children			Spouse/Partnership		
Employer			Co-Workers			Parents		
People in General			Loss of Memory			Feeling Manic		
Trusting Others			Communicating with Others			Eating Problems		
Sleeping Problems			Severe Weight Loss			Severe Weight Gain		
Blackouts			Finances			Sexual Problems		
Legal Problems			Nightmares			Nausea		
Dizziness			Fainting Spells			Chest Pain		
Heart Palpitations			Muscle Tension			Careless Mistakes		
Attention			Fidget Frequently			Obsessive Thoughts		
Speaking without Thinking			Waiting your turn			Completing Tasks		
Grades			Authority			Discipline		
Easily Distracted			Hyperactivity			Learning Disability		
Flashbacks/Nightmares			Taking medication as prescribed			Headaches		

Other: _____

Medical History: Please explain any significant medical problems or symptoms: _____

_____

Medications: Please list any medications that you are currently taking.

Do you use any non-prescription drugs? Yes No If yes, what kind and how often? _____

_____

Do you drink alcohol? Yes No If yes, how much per day/week/month/year? _____

Have friends or family expressed concern about your alcohol or drug use? Yes No

Previous Hospitalizations (Approximate dates and reasons): _____

_____

Have you ever talked with a psychologist, counselor, or other mental health professionals in the past? (If yes, please list approximate dates and reasons):

_____

_____

Do you have a family history of mental illness, addiction, psychiatric hospitalizations or nervous breakdowns? If yes, what was the concern and their relationship to you? _____

_____

Relationship Status: Currently in Relationship? _____ How long? _____ Currently Married? _____ How long? _____

Previously Married? Yes No If yes, how long? _____

Current Relationship Satisfaction (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Describe any problems you are experiencing in the relationship: _____

With whom do you currently live? _____ How long? _____

What are the ages and gender of your children? _____Do they live with you? _____

Employment Status: Employed? ( ) Yes ( )No Occupation? _____ Length of time in Occupation? _____

Please check level of education: ( ) High School/GED ( ) Technical School ( ) Associates ( ) College Degree ( ) Graduate Degree or Higher

Current Employment Satisfaction: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Describe any problems you are experiencing at work: _____

Counseling for Hope and Healing, LLC
INFORMATION, AUTHORIZATION, AND CONSENT TO TREATMENT

Welcome – I am very pleased that you have selected Counseling for Hope and Healing, LLC, and am looking forward to working with you. This document is designed to inform you about the counseling experience and what you can expect during treatment. My name is Catherine Saffels. I am a Licensed Professional Counselor by the state of Georgia and a member of the Licensed Professional Counselor Association of Georgia. I hold two masters degrees: Master of Arts in Professional Counseling from Argosy University, and Master of Divinity from The Southern Baptist Theological Seminary. I also have post-graduate training in the field of Marriage and Family Therapy. I have been working with individuals, couples, families, and groups for thirty years, in residential child care and outpatient counseling settings, both secular and faith-based. I adhere to the professional ethical standards of the American Counseling Association.

Therapy Process – In therapy the client and the counselor work together to achieve the client's goals, which vary according to the individual and the situation. There are no guaranteed outcomes. In order for counseling to be most successful, it is important for you to take an active role. This means attending sessions regularly and actively working on things we talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your sessions. Therapy is a voluntary process. Length of treatment is determined by the client and the therapist together, based on progress and available resources. Clients may terminate at any time without further financial obligation other than fees already accrued. However, it is recommended that you discuss termination with your therapist in order that appropriate referrals may be made.

Confidentiality –Your communications with me will become part of a clinical record of treatment, which is kept locked in a secure place. No release of information is allowed without written prior consent from the client, with the following *exceptions: evidence or reasonable suspicions of abuse/neglect against a minor, elderly person, or dependent adult, or the client expresses intent to harm themselves or someone else, or I am ordered by a judge to disclose information.* Please note that in *couple's counseling*, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner. Records release requires the consent of both parties.

Technology – Although technology brings convenience and multiple means of communication, it also presents challenges regarding confidentiality.
Telehealth: I use Meet, a HIPAA compliant video conferencing platform, to do video or phone sessions. We will need to schedule an appointment for a specific date and time. You will receive an email inviting you to join the meeting (a private session.) Do not share the email/link with anyone in order to protect your privacy. At the time of the appointment you will click the link to join the session. Appointments are 45-50 minutes. I will conduct the session in private, without any other people in the room. You will be responsible for insuring privacy on your end, arranging for a private place and time. If I am not on the line when you join, something is wrong. Please stay in the meeting for up to 5 minutes for me to solve any technical problems which may arise.
Email: It is my policy to utilize email for non-clinical purposes such as sending paperwork. Please do not email therapeutic content to me. If you email information to me it will be printed and held for discussion at our next session and will become part of your clinical record. Please do not use email to cancel or reschedule an appointment.
Text Messaging: Please limit texting to letting me know you will be late for an appointment or need to cancel or schedule an appointment. You may also text me if you are having technical difficulties in connecting for our session.
Social Media - Facebook, LinkedIn, etc.: It is my policy not to accept requests from any current or former client on social networking sites because it may compromise your confidentiality and impact our therapeutic relationship.
Google: It is my policy not to search for my clients on the internet. I respect your privacy and want you to be able to share information about yourself with me as you feel appropriate.

Cancellation – If you are unable to keep an appointment, you must notify me at least 24 hours in advance by calling 404 697-2928. You may leave a voice or text message. Please do not cancel by email. If 24 hour advance notice is not received, you will be charged $25 for the first missed session, $50 for the second and $75 for the third.

Fees -I agree to provide counseling for the fee of $110 per session, 45- 50 minute sessions. The fee for each session is due at the time of service. Mastercard, Visa, Discover and American Express are accepted. If you are not able to pay by credit or debit card, please call in advance to make other arrangements.

Senior Discount: (for people age 65 and older): $75 per session

If I am asked to testify in a court of law, the fee is $200 per hour, including transportation time and time spent waiting in court. If records or summary letters are subpoenaed for court or required for other reasons, there will be a charge of $110 per hour for review of records and composition of report. These costs are not covered by insurance.

Limitation of Services - Counseling services provided do not include the following: custody/visitation evaluations/recommendations, disability evaluations, psychological evaluations, clinical evaluations for DUI, support animal recommendations, FMLA paperwork, or expert testimony in court proceedings. If you need these services, please tell me immediately so that I can help you find a professional who specializes in these services.

If you are in need of emergency services, please call 911 or the Georgia Crisis and Access Line at 800 715-4225. Counseling for Hope and Healing is not an emergency facility. We work by appointment and usually cannot accommodate immediate or same-day service needs. If you have a life-threatening emergency, call 911 or the Georgia Crisis and Access Line, or go to the nearest emergency room.

Professional Relationship: Professional Counseling is a professional relationship and, as such, differs from personal relationships. The counseling relationship is focused on helping you achieve your goals. Because of the need to maintain confidentiality, I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when therapy is completed, I will not be able to be a friend to you like your other friends. It is my duty to always maintain a professional role.

I am looking forward to helping you on your journey toward hope and healing. If you have any questions about the above, please ask.

Please print, date, and sign your name below indicating that you have read, understand, and agree to the contents of this form, and that you wish to begin treatment with Counseling for Hope and Healing, LLC.

Client Signature: _____ Date: _____

Guardian Signature: _____ Relationship: _____

HIPAA Policy Acknowledgement

Counseling for Hope and Healing, LLC, has provided copies of our privacy policies in compliance with HIPAA (Health Insurance Portability and Accountability Act) online at www.counselingforhopeandhealing.com under the Forms tab. A copy of this policy will be given to you upon request. Your signature indicates that you have received the HIPAA policy either online or in print.

Client Signature: _____ Date: _____

Guardian Signature: _____ Relationship: _____