

**Progressive Care Associates, Inc.**  
3415 Old Highway 41, Suite 750 Kennesaw, GA 30144  
(678) 574-8313 | FAX (678) 574-8315

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Client Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years): \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Marital Status:  Never Married  Domestic Partnership  Married  Separated  Divorced  Widowed

Please list any children/age: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (Zip)

Home Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Cell/Other Phone: \_\_\_\_\_ May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

*\*Please note: Email correspondence is not considered to be a confidential medium of communication.*

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred to us: \_\_\_\_\_

**INSURANCE INFORMATION:**

Policyholder's Name \_\_\_\_\_ Policyholder's SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Insurance Co. Name \_\_\_\_\_

Insurance Company's Customer Service Phone # \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Policyholder's Employer: \_\_\_\_\_ Group # \_\_\_\_\_

Co-pay \$ \_\_\_\_\_ Deductible?  Yes  No Amount \$ \_\_\_\_\_ Authorization Required?  Yes  No

Authorization # \_\_\_\_\_ Number of Sessions Authorized \_\_\_\_\_

Max # of Sessions Allowed per Year \_\_\_\_\_ Is the patient covered under a secondary insurance policy?  Yes  No

**GENERAL HEALTH AND MENTAL HEALTH INFORMATION:**

Have you previously received any type of mental health services (therapy, psychiatric services, etc.)?  No  Yes,

If yes, previous therapist/practitioner(s): \_\_\_\_\_

Are you currently taking any prescription medication?  Yes  No

Please list: \_\_\_\_\_

\_\_\_\_\_

Have you ever been prescribed psychiatric medication?  Yes  No

If yes, Please list and provide dates: \_\_\_\_\_

\_\_\_\_\_

1. How would you rate your current physical health? (please circle)

Poor                      Unsatisfactory                      Satisfactory                      Good                      Very good

Please list any specific health problems you are currently experiencing:

\_\_\_\_\_

\_\_\_\_\_

2. How would you rate your current sleeping habits? (please circle)

Poor                      Unsatisfactory                      Satisfactory                      Good                      Very good

Please list any specific sleep problems you are currently experiencing:

\_\_\_\_\_

\_\_\_\_\_

3. How many times per week do you generally exercise? \_\_\_\_\_

What types of exercise do you participate in? \_\_\_\_\_

4. Please list any difficulties you experience with your appetite or eating patterns:

\_\_\_\_\_

5. Are you currently experiencing overwhelming sadness, grief, or depression?  No  Yes

If yes, for approximately how long? \_\_\_\_\_

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?  No  Yes

If yes, when did you begin experiencing this? \_\_\_\_\_

7. Are you currently experiencing any chronic pain?  No  Yes

If yes, please describe: \_\_\_\_\_

8. Do you drink alcohol more than once a week?  No  Yes

9. How often do you engage recreational drug use?  Daily  Weekly  Monthly  Infrequently  Never

10. Are you currently in a romantic relationship?  No  Yes If yes, for how long? \_\_\_\_\_

On a scale of 1-10, how would you rate your relationship? And why? \_\_\_\_\_

\_\_\_\_\_

11. What significant life changes or stressful events have you experienced recently: \_\_\_\_\_

\_\_\_\_\_

**FAMILY MENTAL HEALTH HISTORY:**

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	<b>Please Circle</b>	<b>Family Member</b>
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

**ADDITIONAL INFORMATION:**

1. Are you currently employed?  No  Yes If yes, what is your current employment situation?

\_\_\_\_\_

Do you enjoy your work? Is there anything stressful about your current work?

\_\_\_\_\_

2. Do you consider yourself to be spiritual or religious?  No  Yes  
If yes, describe your faith or belief:

\_\_\_\_\_

3. What do you consider to be some of your strengths?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. What do you consider to be some of your weaknesses?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. What would you like to accomplish out of your time in therapy?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_ (*client or legal guardian*) authorize Progressive Care Associates, Inc. or any holder of medical information about me to release to my insurance company or its representative, any information needed concerning the examination or treatment rendered to me that is necessary to process the insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to be paid directly Progressive Care Associates, Inc. in such amount as my benefits allow. This authorization is effective until terminated in writing by the client or their guardian. **Your signature below also indicates that you have read the Consent for Treatment and HIPPA agreement and agree to the terms.**

PATIENT (or PARENTS/GUARDIANS, IF PATIENT IS A MINOR)

\_\_\_\_\_  
Signature of Patient or Parent(s)/Guardian(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Parent(s)/Guardian(s) (Please print)

\_\_\_\_\_  
Relationship(s) to Patient

OTHER ADULT PARTY/PARTIES INVOLVED IN TREATMENT

\_\_\_\_\_  
Signature of Secondary Party/Parties

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Secondary Party/Parties (Please print)

\_\_\_\_\_  
Relationship(s) to Patient

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Therapist

## CONSENT FOR TREATMENT

Welcome to Progressive Care Associates, Inc. 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), a federal law that provides protections with regard to the use and disclosure of your Protected Health Information used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy. The law requires that I obtain your signature acknowledging that I have provided you with this information. When you sign this document, it will also 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 the process where mental health distresses and disorders are assessed, prevented, evaluated, and treated. There are a variety of techniques that can be used to deal with the problem that brought you to therapy. Psychotherapy has both benefits and risks. Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) or the recall of unpleasant events in your life. Potential benefits include significant reduction in feelings of distress, better relationships, better problem-solving and coping skills, and resolutions of specific problems. Given the nature of psychotherapy, it is difficult to predict what exactly will happen, but I will do my best to make sure you will be able to handle the risks and experience at least some of the benefits. However, psychotherapy remains and inexact science and no guarantees can be made regarding outcomes. Before we begin working together, it is important to understand that I cannot guarantee that you or your child will benefit from therapy. No therapist can make such a guarantee because each client responds differently to this experience.

Therapy usually starts with an evaluation. This evaluation begins with an intake interview and may last more than one therapy session. During the evaluation, several decisions have to be made. I will have to decide if I can provide the services needed to treat your presenting problem. You as a client have to decide if you are comfortable with me. Both of us have to decide on your goals for therapy and how to best achieve them. Therapy generally involves a large commitment so it is your right to be careful about the therapist you select. If you have questions about any of the procedures recommended, feel free to discuss these openly with me. If you have doubts about me as your therapist, I will be happy to help you make an appointment with another mental health professional.

### **Sessions**

If you decide to seek services with me, I will usually schedule one 45-50 minute session (one appointment hour of 45-50 minutes duration) session per week at a mutually agreed upon time. The overall length of psychotherapy (in weeks or months) is generally difficult to predict but is something we can discuss when the initial treatment plan is reviewed with you after the evaluation. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hour notice of cancellation. **Failure to cancel within 24 hours will result in you being charged the full cost of the session.**

### **Contacting Your Therapist**

My office hours vary. You can cancel and/or reschedule sessions by calling my office and speaking with the receptionist or by leaving a message on the confidential answering service. **If you have an emergency, please go to the emergency room at your nearest hospital, or dial 9-1-1. Please note that my office does not have emergency services or facilities.** Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office regular hours, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by a receptionist and you may leave a message for me. I will make every effort to return your call as soon as possible. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your primary care physician, call 911, or call the nearest emergency room. If I will be unavailable for an extended time, I will always inform you and make appropriate arraignments with you. **Contact is not made via email.**

### **Confidentiality**

The law protects the privacy of all communications between a patient and a therapist. In most situations, I can only release information to others about your treatment (or your child's treatment) if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. You should know that I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel it is important for our work together. I will note all consultations in your Clinical Record. You should be aware that I may employ administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling, billing and

communication with insurance companies. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

There are some situations where I am permitted or required to disclose information without either your consent or 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 therapist/patient privilege law. I cannot provide any information without your written authorization, or a court order. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself. If a patient 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. If a patient threatens to harm himself / herself, I may be obligated to seek hospitalization for him/her and/or to contact family members, or others who can help provide protection. If I have reason to believe that a child, elderly or disabled person has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Family and Children Services (DFCS) or an agency designated by the Department of Human Resources.

### **Professional Relationship**

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between my interests and your interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature. You should also know that by law and ethically I am required to keep the identity of my clients a secret. As much as I may like to, for your confidentiality I will not address you in public unless you speak me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, I will not be able to be a friend to you like your other friends and I will not accept friend requests from social networking sites. After your therapy is complete, I will only respond to emails that are in reference to your treatment. Please note that all email correspondence will become a part of your **clinical** record

### **Record Keeping Procedures**

Both law and the standards of the counseling profession require that I keep treatment records. You are entitled to receive a copy of these records, unless I believe that seeing them would be emotionally damaging to you. If this is the case, I will be happy to provide your records to an appropriate mental health professional of your choice. Because client records are professional documents, they can be misinterpreted and can be upsetting. If you insist on seeing your records, it is best to review them with me so that we can discuss their content. All records will be maintained for 7 (seven) years from the termination of service, as required by law. In most situations, I am allowed to charge a copying fee. If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request. In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you or your child with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your or your child's therapy. They also contain particularly sensitive information that you or your child may reveal to me that is not required to be included in your Clinical Record and information supplied to me confidentially by others. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you. They also cannot be sent to anyone else, including insurance companies without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

### **Patient Rights**

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your or your child's record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this agreement; the attached notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

### **Consent for Minors**

Clients under 18 years of age who are not emancipated, as well as their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is typically my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

### **Fees for Service**

I have a set of hourly fees (a session hour is 45-50 minutes). In addition to weekly appointments, I charge this amount for other professional services you or your child may need. Other services include report and letter writing, telephone or email conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. **These services are not covered by your insurance company. No records (written or verbal) will be released to you or on your behalf if you have an outstanding balance due to Progressive Care Associates, Inc.** 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.

You will be charged the missed visit fee for any sessions missed or cancelled with less than 24 hours notice unless due to an emergency situation. You may leave a message on my voicemail on weekends or after hours to cancel an appointment or contact the scheduling department. **Appointments cannot be scheduled or cancelled via email.** Please note that **insurance companies do not pay for missed or cancelled appointments, so you will be responsible for the missed visit fee.** Additionally if you (or your child) miss more than 2 appointments and/or do not give at least a 24 hour notice, that counseling services may be discontinued and you will receive an appropriate referral.

### **Insurance, Billing and Payments**

You will be expected to pay for each session at the time it is held, unless you have insurance coverage or we agree otherwise. If you have insurance, you are required to pay your co-pay/deductible at the time of service. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I 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 me to disclose otherwise confidential information. If such legal action is necessary, its costs will be included in the claim.

When using insurance is **very important that you find out exactly what mental health benefits your insurance policy provides, such as co-pays, deductibles, maximum number of sessions allowed, etc.** You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. If it is necessary to clear confusion, I, or my staff, will be willing to call the company on your behalf. Many insurance plans such as HMOs and PPOs require authorization before they provide reimbursement for mental health services. **It is your responsibility to call your insurance company and obtain authorization before your first appointment. If authorization was required and is not obtained, your insurance will deny payment and you will be responsible for the hourly rate.** I will submit the appropriate bills to your insurance company one time and try to remedy any denial or payment problem related to billing one time. If after these billing attempts, the insurance company refuses to pay the bill, it will become your (the client's) responsibility to work with the insurance company to obtain appropriate reimbursement.

You should understand that Progressive Care Associates, Inc. will assist you in submitting claims to all insurance coverage that you provide; however, the ultimate financial responsibility for services provided by Progressive Care Associates, Inc. is yours. **Failure of insurance to pay a claim will not mitigate any claim Progressive Care Associates, Inc. may have for services provided to you (or your child).** Additionally, if you continue to incur fees that are your responsibility for services rendered, Progressive Care Associates, Inc. has the right to and may terminate therapy and you will receive an appropriate referral.

**Authorization for Recording**

In order to conduct business in a quick and seamless fashion, we may have to contact you or your insurance company via the telephone. These conversations are recorded by our office and records are maintained and kept in the same manner as your Clinical Record. This ensures that our office has evidence if there is ever a dispute over a scheduled appointment, authorization of a credit card, or approval of insurance coverage. At no time will medical issues or therapy be discussed or recorded during a telephone call to our office.

**Court Attendance, On-Call, and Communication with Attorneys/Other Professionals**

Progressive Care Associates, Inc. bills at the rate of \$200.00 per hour for court attendance and requires credit card information to be on file. The hourly rate begins when the therapist leaves the office location and a fee for two hours will be paid prior to court attendance, (\$400.00) and is non-refundable if less time is needed. If the court attendance exceeds two hours, your credit card will be billed for the remaining time. Payment is for the therapist's time and not necessarily their testimony. Therefore, the fees are expected to be paid regardless of whether the therapist testifies or not. If you request for your therapist to be on-call for court attendance, Progressive Care Associates, Inc. bills at the rate of \$60.00 per hour for on-call and requires credit card information to be on file for payment to be charged. The hours requested for the therapist to be on call will immediately be charged to your credit card on file and is non-refundable.

**Communication with Attorneys/Other professionals/Report writing:**

Progressive Care Associates, Inc. bills at the rate of \$100.00 per hour for any type of communication with attorneys/other professionals/report writing (phone calls, letter writing, email, etc). You are responsible for providing credit card information prior to any communication your therapist will have with their attorney/other outside professional. A minimum of 30 minute increments will be billed to your credit card on file and is non-refundable.

**Records Request**

Progressive Care Associates, Inc. bills a flat rate of \$25 for records to be copied and faxed/given to the client. If records need to be mailed, an additional fee of \$10 is assessed to cover certified mail and postage. After payment is received and processed, please allow up to 7 business days for copies to be provided and/or mailed.