Lullwater Counseling

1244 Clairmont Road, #204
Decatur, Georgia 30030

NEW CLIENT INFORMATION FORM

Name: _____Date of Birth:_____ Age: _____

Address: _____ City: _____ ZIP: _____

Phone: _____ Is it ok to leave a message? _____ Is it ok to text? _____

May I contact you via email? _____ Yes _____ No Email Address: _____

Relationship Status: _____Gender Identity:_____ Sexual Orientation:_____ Pronouns:_____

Years of School Completed: _____Employer/School_____

Who referred you? _____May I thank that person? _____Yes _____No

Whom to notify in case of emergency: _____ Relationship: _____

Contact phone number: _____ Military Experience:_____ Religious Affiliation_____

What, if any, previous therapy or psychological treatment have you experienced? Please include the year.

What prescription medications do you currently use and how often do you take them?

Have you ever been prescribed psychiatric medication (for example, for depression or anxiety, etc)?

How much alcohol do you use and how often do you use it?

Have you ever been treated for alcohol abuse? Have you had a DUI?

What drugs do you use and how often do you use them? Have you ever been treated for substance abuse?

Have you had problems with or been treated for a process addiction (eating disorder, gambling, sex, porn, hoarding, shopping)?

Does anyone in your immediate family have a substance abuse problem?

Have you experienced sexual, physical, verbal or emotional abuse?

Have you ever felt your life or safety was at risk?

Do you feel safe in your current living situation?

Have you had any interactions with the Department of Family and Children Services (DFCS)

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Please indicate any of the following problems or symptoms you are or have recently been experiencing:

__Abuse	__Aggression	__Alcohol Abuse
__Anger	__Apathy	__Anxiety
__Appearance Concerns	__Appetite Concerns	__Assertiveness Concerns
__Bereavement/Grief	__Career Concerns	__Communication problems
__ Concentration Problems	__Depression	__Disability
__Discrimination	__Disorganization	__Distractibility
__Domestic Violence	__Eating Disorders/concerns	__Family of Origin issues
__Fatigue	__Financial problems	__Hallucinations
__Harassment	__Helplessness	__Hopelessness
__Hostility	__Impulse Control problems	__Indecision
__Insomnia	__Irritability	__Lack of energy
__Lack of support system	__Learning disorder	__Legal problems
__Loneliness	__Low self-esteem	__Marital problems
__Medical problems	__Motivation difficulties	__Parenting concerns
__Partner/spouse concerns	__Peer group problems	__Racing thoughts
__Relationship issues	__Restlessness	__Sadness
__School problems	__Self-defeating behavior	__Self-injury
__Sexual orientation questions	__Sexual problems	__Sleep changes
__Spirituality/religious concerns	__ Stress	__Substance abuse
__Suicidal thoughts	__Tearfulness	__Tension
__Thoughts of hurting others	__Unable to break a bad habit	__Weight loss or gain
__Withdrawal from others	__Workplace difficulties	__Worrying excessively

Please describe briefly what brings you to therapy at this time.

_____ _____

Signature Date

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Psychotherapy Services Contract

Psychotherapy Services: Psychotherapy is a process that involves activity on the part of the therapist and client. Emotional risk is a part of this process. Therapy has been shown to improve relationships, reduce feelings of distress and increase self-efficacy in the world. Yet, this exploration can produce painful feelings such as sadness, anger, and frustration. Our first few sessions will involve an assessment of your presenting concerns and life circumstances. Together we will develop a treatment plan. I encourage you to ask me for feedback throughout this process.

Charges: All fees for therapy are per session and are subject to change. Each session lasts 50 minutes. Phone calls extending beyond 10 minutes will be billed at a pro-rated amount. Administrative services are billed at the same rate as therapeutic services. All legal services are billed at $350 per hour.

Good Faith Estimate: Fees for service will be determined prior to the initial session. Depending on services needed and degree of difficulty, you may need between 5 and 30 sessions. The length of time in therapy depends on your therapeutic goals. You may terminate therapy at any time.

Payment: Payment is expected at the time of treatment. There are no charges for appointments cancelled 24 hours in advance and are negotiable in cases of sudden illness or accidents. All other missed appointments are billed at the regular fee.

Evaluation and Treatment: Together we will explore your presenting problems and discuss the treatment options. We will develop a working relationship to explore alternatives and solutions to the difficulties you are experiencing. Once your treatment goals are met, we will collaborate in making the decision to terminate treatment. Regular participation in therapy is required in order for therapy to be effective. Irregular attendance may be a sign of conflicted feelings about therapy, which we can discuss. If appointments are regularly missed, the therapy will not be productive.

Confidentiality: All treatment records and information are maintained in the strictest confidentiality as required by law. Child endangerment and/or abuse, elder abuse, molestation and neglect are required to be reported to the appropriate authorities, as is the threat of imminent harm to oneself or to another. **There are other possible limits to my ability to maintain confidentiality. Please read the attached Notice of Privacy Practices and Office Policies and Procedures.**

Emergency Procedures: Leave a message for your therapist. Indicate the nature of your emergency. Your therapist will respond as soon as possible. Meanwhile, you may do one of the following things:

1. Call a friend or another member of your support network
2. Call the Georgia Crisis and Access Line 1-800-715-4255 or National Mental Health Line 988
3. Go to the nearest emergency room hospital
4. Call 911 (last resort)

I understand and agree to these conditions and I consent to this therapy contract.

_____ _____

Signature Date

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Office Privacy Policies & Procedures

Confidentiality and privacy are the cornerstones of the mental health professions. Clients have an expectation that their communication with therapists and their treatment records will be kept confidential and will not be released to others without the written authorization of the patient. One of the purposes of the Notice of Privacy Practices is to inform and educate clients about general rules of confidentiality and their exceptions. My office policies and procedures, as well as the ethical standards of my profession, are intended to shape my practice so that the privacy and confidentiality are maintained, consistent with Georgia law and the federal "Privacy Rule."

1. Privacy Officer. I, Dayle Doreen Hosack, LMFT, am the privacy officer for Lullwater Counseling. I am the one responsible for developing and implementing policies and procedures.
2. Contact Person. I, Dayle Doreen Hosack, LMFT, am the contact person for Lullwater Counseling. If a client needs or desires further information related to the Notice of Privacy Practices, or if the client has a complaint regarding these policies and procedures or my compliance with them, I am the person who should be contacted.
3. The effective date of these policies is April 14, 2003.
4. I will maintain documentation of all consents, authorization, Notices of Privacy Practices, Office Policies and Procedures, trainings and client requests for records or for amendments to records. I will also document complaints received and their disposition. You will be notified if these policies are revised.
5. I will not maintain or use client sign-in sheets.
6. Conversations regarding confidential material or information, when required by law, will take place in an area and in a manner where they will not easily be overheard.
7. Client records will be kept in file cabinets in my individual office. My office is locked when I am not here. Client records will not be left in places in my office where others are able to see the contents. I will take steps to assure that client records are accessed only by me.
8. Information and records concerning a client may be disclosed as described in Notice of Privacy Practices and in accordance with applicable law or regulation. Generally, I will obtain a written authorization from the client before releasing information to third parties for purposes other than treatment payment, and health care operations, unless disclosure is required by law or permitted by law.
9. If mental health records are subpoenaed by an adverse party I will assert the psychotherapist-client privilege on behalf of the client and will thereafter act according to the wishes of the client and the client's attorney, unless I am ordered by a Court or other lawful authority to release records or portions thereof.
10. I keep client records for at least seven years from date of last treatment. With respect to the records of a minor, I keep those records for at least seven years or until the client is 21 years old, whichever is longer. Thereafter, I may destroy client records. When records are destroyed, they will be destroyed in a manner that protects client privacy and confidentiality.
11. I will attempt to find out from clients whether they have any objection to me sending correspondence to their residence (e.g., claim forms, bills, etc) and whether I am permitted to call them at their residence or elsewhere to discuss matters related to their treatment.
12. My duty of confidentiality and the psychotherapist-client privilege survive the death of a patient.
13. I will do my best to ensure that electronic information, such as billing records and correspondence, is protected from computer viruses and unauthorized intruders.
14. Computers and fax machines will be placed appropriately so that access is limited to office personnel and so that confidential information transmitted or received is not seen by others.

_____ _____

SIGNATURE DATE

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04-818-6535

NOTICE OF PRIVACY PRACTICES

This notice describes how your treatment records may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosures Permitted Without Your Authorization

The following are circumstances when disclosure without your authorization may or will be made:

1. If disclosure is compelled by a court pursuant to an order of court, subpoena, notice to appear, or any provision authorizing discovery in a court proceeding or administrative agency.
2. If disclosure is compelled by a board, commission or administrative agency for purposes of adjudication or investigative subpoena to its lawful authority.
3. If disclosure is compelled by a search warrant lawfully issued by a governmental law enforcement agency.
4. If disclosure is compelled by an act of state or federal law:
   a. I must by law report any knowledge or suspicion of child abuse and/or elder/dependent adult abuse.
   b. I must report any knowledge or suspicion of imminent harm of person or property to oneself or another.
5. If disclosure is compelled or permitted, in the event of your death, to the coroner in order to determine cause of death.

Client Rights

1. Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction request.
2. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations.
3. Right to Inspect and Copy Protected Health Information. You may make a specific request in writing for copy of protected health information. I am permitted to deny access for specific reasons. You may have my decisions reviewed.
4. Right to Amend. You have the right to request an amendment of your protected health information. I am permitted to deny the requested amendment for specified reasons.
5. Right to an Accounting. You generally have the right to receive an accounting of disclosures of your protected health information.
6. Right to a Paper Copy. You have the right to obtain a paper copy of this notice from me.

Practitioner Duties

1. I am required by law to maintain the privacy of personal health information and to provide you with a notice of my legal duties and privacy practices.
2. I am required to abide by the terms of the notice currently in effect. I reserve the right to change the terms of this notice and/or my privacy practices. If I make a revision to this notice, I will make the notice available at my office upon request.

I understand and agree to these conditions.

_____ _____

Signature Date