

Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected as confidential information.

Personal Information

Name: _____ Date: _____

Preferred Name: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____ May we leave a message? Yes No

Cell/Work/Other Phone: _____ May we leave a message? Yes No

DOB: _____ Age: _____ Gender: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Referred By (if any): _____

General and Mental Health Information

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating problems: _____

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

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panics attacks or have any phobias? No Yes

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? No Yes

If yes, please describe: _____

Do you drink alcohol more than once a week?

Daily Weekly Monthly Infrequently Never

How often do you engage in recreational drug use other than alcohol?

Daily Weekly Monthly Infrequently Never

If yes, what drug(s)?

How would you describe your sexual orientation? _____

Marital Status:

- Never Married Domestic Partnership Married
 Separated Divorced Widowed

Please list names and ages of any children:

Psychiatric History

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

If yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? No Yes

If yes, please list:

Have you ever had a psychiatric hospitalization? Yes No

If yes, please list and provide dates:

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 (e.g. father, grandmother, uncle, etc.)

	<u>Please Circle</u>	<u>List Family Member</u>
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____
Anger Issues	yes / no	_____

Additional Information

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? _____

What is your highest level of education completed? _____

Have you ever been physically abused: Yes No

Have you ever been sexually abused: Yes No

Have you experienced anything you would describe as trauma? Yes No

If yes, please briefly explain:

Do you consider yourself to be spiritual or religious? Yes No

If yes, describe your faith or belief: _____

What do you consider to be some of your strengths? _____

What do you consider to be some of your weaknesses? _____

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

What else would you like for me to know?

Sign

Date

Reviewed by clinician

Date

**THE CENTER FOR MINDFUL EXPLORATION
1111 Mooty Bridge Road, Ste A/ PO BOX 564
LAGRANGE, GA 30241**

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices, effective April 1, 2016, describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. Any PHI will only be released in accordance with state and federal laws and the ethics of the counseling profession.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services.

For Payment. I may use or disclose PHI so that I can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, or reviewing services provided to you to determine medical necessity.

Other uses and disclosures permitted by HIPAA without your consent.

- Abuse and Neglect
- Emergencies
- Audits or Investigations
- National Security
- Judicial and Administrative Proceedings
- Law Enforcement
- Public Safety (Duty to Warn)
- Required by Court Order

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR PHI

Right of Access to Inspect and Copy. You have the right, which may be restricted only in circumstances where there is compelling evidence that access would cause serious harm to you, to inspect and copy PHI that may be used to make decisions about your care.

Right to Add Information or Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may submit a written request to amend the information, although I am not required to agree to the amendment.

Right to a Copy of this Notice. You have the right to a copy of this notice and the right to receive any future changes in policy.

I have read this notice and fully understand its content.

Client Name

Client Signature (Parent/Guardian if Under 18) Date

The Center for Mindful Exploration, LLC
OFFICE POLICIES AND PROCEDURES

The policies and procedures of this office have been created in an effort to improve service and to minimize inconvenience to our patients. It is my hope that by familiarizing you with these policies in advance, we may prevent misunderstanding and potential confusion or other difficulties.

OFFICE HOURS: Traditional office hours are from 8:00 A.M. until 6:00 P.M. Monday through Thursday, though individual therapists may work different hours. Our phone number is 706-443-5433. We are generally in session, but you can leave your name, number and message and someone will return your call within two business days.

APPOINTMENTS: Visits are by appointment only. However, if an urgent need should arise, we will make every effort to see you that day if possible. If you are unable to wait for a call back or your need is emergent, please proceed to your nearest hospital emergency department or call 911 for any potential life-threatening event. You can also call the Georgia Crisis Line at 800-715-4225.

LETTERS AND FORMS: Our therapists do not fill out disability or FMLA forms. Recommendations for these types of forms are best suited for doctors. There is a \$30 charge for any letter you request from your therapist.

TREATMENT EXPECTATIONS: Many things affect the success of treatment. The severity of the problem, the match between the clinician and patient, and the motivation of the patient, among other factors affect the length of treatment. We can discuss your feelings about your treatment and whether it is meeting your needs at any time.

Typically, the decision to terminate therapy is made by mutual consent of clinician and patient. In the event that you decide to discontinue treatment without notifying your clinician, it is assumed and formally agreed upon that the therapeutic relationship terminates 30 days after your last visit.

CONSENT TO TREAT: I give consent to Susan. Marshall, LPC / LaShannon Epps, LPC to provide any mental health/substance abuse care deemed necessary to accurately diagnose and treat my condition.

FEES: Appointments are generally 55 minutes. Initial appointments are \$125 and follow-up appointments are \$100. If you need to cancel an appointment, **YOU MUST CANCEL BY 5PM THE PREVIOUS BUSINESS DAY.** This allows us time to schedule another patient for that period. A CANCELLATION CHARGE OF \$50 WILL BE MADE FOR MISSED APPOINTMENTS WITHOUT NOTICE BY 5PM THE PREVIOUS DAY. Your appointment time was reserved for you and may not be able to be refilled on such short notice. Payment in full is required at the time of service unless other arrangements have been made in advance. A \$35 service charge will be made for all returned checks.

A copy of this form is available for your records

I have fully read, understand, and agree to the above policies and consent.

Patient/Guardian Signature _____ Date _____

Printed Name of Patient or Guardian: _____

Social Security Number _____ Date of Birth _____

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AUTHORIZATION FOR RELEASE OF INFORMATION PRIMARY CARE PHYSICIAN OR PSYCHIATRIST
(REQUIRED BY INSURANCE)

I, _____, give full authorization to provide/exchange information regarding my mental health information to/with:

Name (Primary Care Provider or Psychiatrist)

Phone Number

Street Address

City, State, Zip Code

for the purpose(s) of:

coordination of care

I understand that authorization shall remain valid from the date of my signature below and ending one year from the date this authorization is signed.

I have been informed that I may revoke this authorization by written communication at any time.

I certify that this form has been fully explained to me and that I understand its contents.

Signature of Client or Legal Guardian

Date of Authorization

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AUTHORIZATION FOR RELEASE OF INFORMATION FOR BILLING

I, _____, give full authorization to provide/exchange information regarding my mental health information to/with:

Name of Insurance Provider

Insurance ID #

Group #

Name of Primary Insured

Primary Insured's Date of Birth

for the purpose(s) of: Billing

I understand that authorization shall remain valid from the date of my signature below and ending one year from the date this authorization is signed. I have been informed that I may revoke this authorization at any time.

I certify that this form has been fully explained to me and that I understand its contents.

INSURANCE POLICIES: Please be aware that some insurance companies require the insured patient to contact them in advance of any scheduled visit to obtain pre-authorization for services. You are solely responsible for meeting this or any other obligation of your contract with your insurance company prior to the time of your visit. Your insurance co-payments and deductible fees are required in full at the time of service.

Your insurance coverage is a contract between you and your insurance company. As a courtesy to you, I will be happy to file a claim for your visit on your behalf. **The ultimate responsibility for payment, however, remains with you.** Accordingly, any account balance over thirty (30) days old will be billed directly to you. Should your account have to be collected through a collection agency or an attorney, you shall also be responsible for all reasonable attorney's fees and all costs of collection. Please be aware that all unpaid balances will be referred to a collection agency if you fail to fulfill your financial obligations

Signature of Client or Legal Guardian

Date of Authorization

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AUTHORIZATION FOR RELEASE OF INFORMATION EMERGENCY CONTACT/ OTHER

I, _____, give full authorization to provide/exchange information regarding my mental health information to/with:

_____ Relationship: _____

Name

Phone Number

Street Address

City, State, Zip Code

___ I DO NOT want any information released to my significant others, but I realize if my safety is at risk this desire may not be applicable.

I understand that authorization shall remain valid from the date of my signature below and ending one year from the date this authorization is signed.

I have been informed that I may revoke this authorization by written communication to Susan Marshall, LPC at any time.

I certify that this form has been fully explained to me and that I understand its contents.

Signature of Client or Legal Guardian

Date of Authorization

The Center for Mindful Exploration Contact Sheet

Patient Name: _____

DOB: _____

Social Security #: _____

Please indicate how you would like to be reminded of your upcoming appointment

Circle:
Phone or Text

Please provide the **phone number** for your reminder:

Please provide your **email address**:

- Check here if you would like to access the patient portal.
- Check here if you'd like to be added to our email list for updates on classes, workshops and retreats.

I hereby give authorization for the aforementioned means of contacting to remind me.

Patient's (or legal guardian) Signature

Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: MasterCard VISA Discover AMEX Other

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

CVV: _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize The Center For Mindful Exploration to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature

Date