Therapeutic Impressions, LLC
Jessica B. Sheridan, LCSW
104 Pilgrim Village Dr * Suite 300 * Cumming GA 30040
Cell: 678-595-2020 * Fax: 770-406-8872
www.therapeuticimpressions.com

Client Registration Form

First Name: _____Last Name: _____MI: _____ DOB: _____

Address: _____ Age: _____
City: _____ State: _____ Zip: _____ Sex: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____

SSN: _____-_____-_____ Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Other: _____

Responsible Party: _____Relationship: _____

Occupation: _____ Employer: _____
Employer City: _____Work Phone: _____

Client's Spouse or Parent: _____ Telephone #: _____

Emergency Contact: _____ Telephone #: _____
Relationship: _____

How were you referred to our office? _____

Preferred Method of contact: _____Text _____Home _____ Cell _____ Work _____ Email

Insurance Information

Company Name: _____ Telephone #: _____
Member ID #: _____ Group #: _____
Policy Holder: _____ Relationship: _____
Policy Holder's Social Securtiy No. (if different from Client): _____-_____-_____
Policy Holder Date of Birth: _____

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to Therapeutic Impressions, LLC for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that if I will be charged the insurance allowable rate, or standard fee if private pay, for any missed appointments which are not rescheduled or cancelled within **24** hours of the scheduled appointment time. I authorize Therapeutic Impressions, LLC to file a claim for these services (and to refile as necessary to collect) with the patient's insurance(s) and bill the patient for any amounts for which they are responsible. I further authorize Jessica B Sheridan to sign said claim(s) or any refiled claims on my behalf. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collection expenses.

_____
Client Name

_____ _____
Client or Parent/Guardian Signature Date

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Informed Consent

Client Name: _____ DOB: _____ Date: _____

X_____I understand that I will be receiving an assessment, evaluation, and/or treatment from Jessica B. Sheridan, LCSW. The type and extent of services that I will receive will be determined following an initial consultation.
X_____Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear and anger. Intense feelings of anxiety, depression, loneliness, or helplessness may also be aroused.
X_____ I understand that Therapeutic Impressions, LLC does not provide crisis treatment after hours and if I believe I am a danger to myself or others I will contact the Georgia Crisis Hotline at 1-800-715-4225 or call 911.
X_____ You should know that your therapist is not a physician and cannot prescribe or provide you with any drugs or medication or perform any medical procedures. If medical treatment is indicated, your therapist can recommend a physician or psychiatrist for you or you can choose a health care professional you wish to see.

CONFIDENTIALITY

X_____ Confidentiality and privileged communication remain the right of all clients of counselors according to Georgia State Law. I understand that information concerning treatment or evaluation may be released only with the sole authorization and consent of the person treated or evaluated, or such person's parent/guardian, and with the agreement of the counselor. There are exceptions to the confidentiality of information in the following circumstances (as provided by law): (1) Where there is a clear and imminent danger to the client or others, the counselor may take reasonable personal action or inform the responsible authorities; such as in, suspect of child abuse or suicidal ideation or homicidal ideation will be reported; and (2) if the counselor is required by a court to give information. Except as required by law, you, the client/parent/guardian must sign an authorization to release clinical records to the counselor to talk to or share clinical records or information with anyone, including referred doctors, insurance companies, or family members. All people attending sessions would be required to sign a consent to authorize release of clinical records. Counselors will be discreet if it is necessary to contact you at home or work. In keeping with generally accepted standards of practice, counselor frequently consults with other mental health professionals regarding the management of cases. The purpose of this consultation is to insure quality care. Every effort is made to protect the identity of clients, including any financial records (including payment via credit/debit card information).
X_____ I understand that appointment reminders can be made over email/phone/text and this is not HIPPA compliant. Therapeutic Impressions LLC is not responsible for a breach of information through email account or phone.

ACKNOWLEDGMENT OF DISCLOSURE

X_____ The client/parent/guardian has the responsibility and right to (1) choose their therapists and the treatment modality that best suits their needs; (2) discuss with the counselor any concerns about treatment; (3) request a change in approach; (4) request referral to another therapist; and/or (5) discontinue therapy. The counselor can make no guarantees of results. The counselor follows the ethical guidelines set forth by the National Association of Social Workers.
X_____ You have the right to obtain a paper copy of this notice from us, upon your request, even if you have agreed to accept this notice electronically. You are also agreeing that you have read the Notice of Privacy and agree with it.

CANCELATION POLICY AND FEES

X_____ If you must cancel your appointment, please phone at least 24 hours prior to your scheduled time. Please understand that you are responsible for the time reserved and for notifying your counselor when a change in appointment time is needed. You will be charged a flat fee of **$50.00** for any appointment that does not meet this specification. The **exception** is in case of **extreme emergency**, meaning serious illness or an impossible situation; however, your counselor has the right to use discretion as to what an emergency entails.

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Addendum to Patient Registration Form
Informed Consent

Payment of Fees for Denied and/or Non-Covered Services

I, _____, understand that some services may not be considered eligible benefits (e.g., services and/or supplies may be determined to not be medically necessary, non-covered or investigational) by my health insurance provider.

I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements and non-covered services.

Examples of these non-covered items include, but are not limited to, multiple visits in one day, court documentation, depositions, report writing, in person or phone conferences and/or meetings and supplies.

Examples of Standard Fees:

Court Appearance (must be paid PRIOR to scheduling) - $1,200.00

Depositions (must be paid PRIOR to scheduling) - $150.00/per hour

Patient Phone Consults (unrelated to scheduling matters) - $50.00/per hour (billed at a minimum of 15 minutes)

Multiple visits in one day - Your contracted insurance allowable rate for same service type
I agree to be financially responsible for any and all related charges if they are not covered by my health insurance.

_____
Client or Parent/Guardian Name

_____ _____
Client or Parent/Guardian Signature Date

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Financial Policy

When you begin services with your therapist you will be placed in one of the following payment account categories:

1) If you choose not to use insurance benefits, or you do not have insurance benefits, you will be placed in a "private pay category." The fee for your sessions will be agreed upon prior to your first session and all payments are due at the time services are rendered.

2) If you would like to use your in-network or out-of-network insurance benefits and you **have met** your deductible, Therapeutic Impressions, LLC will be happy to file your insurance claim. You will be placed in an "insurance pay category." Any co-pays or coinsurance fees will be due at the time services are rendered.

3) If you would like to use in- or out-of-network insurance benefits but you **have not met** your deductible, you will be placed in a "private pay category" and you will be provided a Superbill. A Superbill is a statement used by members to file a claim to their insurance company for credit toward the deductible or for reimbursement of fees paid out of pocket. Please note: The deductible/reimbursement fee typically differs from the private pay fee and you may not be credited or reimbursed the full amount of the private pay fee. Once your deductible has been met you will be moved to an "insurance pay category."

4) If you choose to utilize Employee Assistance Program (EAP) benefits, you will be placed in an "EAP category." Your EAP will be billed for all session fees. It is your responsibility to ensure that your therapist has your EAP company information, authorization number, and how many sessions are authorized. In the event that the EAP refuses payment, you will then be placed in a "private pay or insurance pay category" and you will be responsible for any payments owed to the therapist.

Please Note:

- Therapeutic Impressions counseling services requires a 24 hour notice if you cannot make your appointment time. A $50 cancellation/no show fee will apply if you do not provide 24 hour notice.
- If you request that an invoice of your services be sent to you via email, you are agreeing that you understand that email may not be a secure correspondence and you do not hold Therapeutic Impressions, LLC responsible for any breach of information through your email account.
- Copays and other session fees may be paid with money order, cash, check, or credit card. A $25 fee may be charged for any returned checks.

By signing below, you are acknowledging and agreeing to this financial policy.

_____ _____

Client or Parent/Guardian Signature Date

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Client Intake Information

Client Name: _____ DOB: _____ Date: _____

Counseling Concerns

Why are you seeking help now? _____
_____
_____
_____

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

How would you rate current stress level? None 0 1 2 3 4 5 6 7 8 9 10 Extreme

Medical/Psychological History

Physician's Name/Number: _____

List of physical illnesses/symptoms: Check if none _____
_____
_____ Date of last physical:
_____ _____
_____

Current Medication Dosage Frequency Prescribing Doctor
_____
_____
_____
_____

Psychiatrist Name/Number: _____

Have you had counseling before? _____ With whom?_____ When? _____

How would you rate effectiveness of previous counseling? None 0 1 2 3 4 5 6 7 8 9 10 Excellent

Hospitializations:_____
_____

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Any developmental issues/delays? _____
_____

Rate your eating habits: Can't Eat Eating Normally Over Eat _____

Rate your sleeping habits: Poor Fair Good Excellent _____

Current steps are you taking towards your physical health: _____
_____

Hobbies and activities done for pleasure: _____
_____

Check which of the following used and frequency:

Tobacco_____	Coffee_____	Drugs_____	Marijuana_____
Pills_____	Sodas_____	Alcohol_____	

Interpersonal Relationships

Name/age of family members living in house: _____
_____
_____

Closest family member to client: _____

Concerns with family dynamics:_____
_____

Desired changes within home: _____
_____

Please rate your current satisfaction level of home environment: None 0 1 2 3 4 5 6 7 8 9 10 Excellent

Issues with parenting: _____
_____
_____

Rate your current stress with finances: No stress 0 1 2 3 4 5 6 7 8 9 10 Very stressed

Anything else important to know about you: _____
_____
_____

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Checklist of Concerns

(Please check all that are applicable)

Client Name: _____ DOB: _____ Date: _____

Thoughts/Feelings/Mood

□ Anger/frustration/hostility
□ Inattention
□ Depression
□ Excessive worry
□ Fear
□ Grieving (death, divorce, etc.)
□ Hallucinations
□ Intrusive thoughts
□ Judgement problems
□ Memory difficulties
□ Negative thoughts
□ Obsessive thoughts
□ Panic attacks
□ Sadness
□ Self-esteem
□ Shyness
□ Stress
□ Sudden mood changes
□ Suicidal or Homicidal thoughts

Family & Relationships

□ Affair
□ Childhood issues (your childhood)
□ Divorce/Seperation
□ Interpersonal conflicts
□ Parenting
□ Relationship
□ Problems/Differences

Work & School

□ Absenteeism
□ Career concerns, goals, choices
□ Difficulty with coworkers/peers
□ Difficulty with supervisors/teachers
□ Performance
□ Tardiness
□ Procrastination
□ School problems

Behavior

□ Abuse
□ Aggression, violence
□ Alcohol use
□ Argumentative
□ Compulsive behavior/rituals
□ Controlling
□ Decreased/lack of sexual interest
□ Destruction of property
□ Eating problems
□ Financial problems, debt
□ Hyperactivity
□ Internet problems
□ Isolation
□ Legal problems
□ Codependency
□ Lying
□ Not able to relax
□ Eating Disorder
□ Self destruction/sabatoging
□ Self-neglect
□ Sexual dysfunction
□ Stealing
□ Weight, gain/loss
□ Withdrawal from others
□ Loss of interest in former pleasures
□ Sleep difficulty

Addiction

□ Abuse of alcohol
□ Abuse of drugs
□ Dependency
□ Drug use—prescription, over-the- counter, street
□ Gambling
□ Pornography
□ Preoccupation with sex

Other Concerns _____
_____
_____
_____

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Release of Information

Client Name: _____ Date: _____

X_____ To be compliant with HIPPA, we must have your written consent to release any of your mental health records to ANYONE. Please list the names and a contact phone number for anyone you give permission to have your records released to if needed. Please keep in mind family members, medical professionals and court personnel when completing this form.

Name	Phone Number	Relationship

I have read and understood the prior statements including the confidentiality form, the disclosure information, the informed consent information, the appointment cancellation policy, and the information regarding consent to release records. My signature indicates that I hereby give my consent for counseling services. I authorize Therapeutic Impressions, LLC to render counseling services to the following:

_____ _____
Client Name Date

_____ _____
Client or Parent/Guardian Signature Date

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Credit Card Authorization Form

Client Name: _____

Cardholder Name: _____

Billing Address: _____

City, State, and Zip: _____

Cell Phone Number: _____

Email Address: _____

Credit Card Type: _____ Visa _____ Mastercard _____AmEx _____ Discover _____ Flex Card

Credit Card Number: _____ Expiration Date: _____

Card Identification Number (last 3 digits located on the back of the credit card): _____

I, _____, authorize Therapeutic Impressions, LLC to charge to my credit card provided herein any amounts due on my account. I agree to have Therapeutic Impressions, LLC maintain my credit card information on file and automatically charge my credit card when payments are due. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. I agree to inform Therapeutic Impressions, LLC within 15 days of any changes in credit card information, and I agree to pay any fees in the event my credit card is declined.

_____ _____

Cardholder Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicates that you have been given the opportunity to review and retain a copy of the Notice of Privacy Practices on the date indicated below.

If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact Jessica B Sheridan at any time.

_____
Client Name (Printed)

_____
If Client Representative, Name (Printed)

_____
If Client Representative, Relationship to Client (Printed)

_____
Account Number (Office Use)

_____
Client or Representative Signature

_____
Date Notice Received

Social Media Policies

Please be advised our counselors do not accept "friend" or contact requests from current or former patients on any social/professional networking site (Facebook, LinkedIn, Twitter, Instagram, etc.). These sorts of connections may compromise your confidentiality and our respective privacy. These connections also may blur the boundaries of our therapeutic relationship and potentially have unforeseen negative consequences for you as my patient.

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Medicaid/Medicaid CMO Missed Appointment Addendum

Attention all Medicaid, Amerigroup, Wellcare and Cenpatico Patients

Please be advised that if you are a Medicaid or Medicaid CMO recipient, and you miss three (3) appointments, your care is subject to termination at the discretion of your provider. It is very important that you show up timely to all appointments scheduled and to remember to reschedule if necessary.

If you have any questions regarding this standard, please do not hesitate to contact our office at any time.

_____
Client Name (Printed)

_____
If Client Representative, Name (Printed)

_____
If Client Representative, Relationship to Client (Printed)

_____
Client or Representative Signature

_____
Date Notice Received