Therapeutic Impressions, LLC
104 Pilgrim Village Dr * Suite 300 * Cumming GA 30040
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: __________________________________

Client's Spouse or Parent: _________________________________ Telephone #: ________________________________

Emergency Contact: ______________________________________ Telephone #: _______________________________
Relationship: ____

How were you referred to our office? ____

Preferred Method of contact: _____Text _____Home _____ Cell _____ Email

Insurance Information

Insurance 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 $75 fee 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 Therapeutic Impressions, LLC 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.
There will be a $2 credit card fee if paying for services with a credit card or invoice. You may pay check or bring cash ahead of session date if you prefer.

____
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 a clinician of Therapeutic Impressions, LLC. 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 **$75.00** 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.

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.

Litigation Limitation:

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure regarding confidential matters, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) neither you (client), your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the therapy records be requested. I will not be asked to write a letter for court purposes regarding the nature of what is discussed in sessions. Should a brief written statement be required by Court, an affidavit form must be provided.

Examples of Standard Fees:

Court Appearance (must be paid 5 days PRIOR to court date) - $1,500.00

Depositions (must be paid5 days PRIOR to deposition date) - $150.00/per hour

Affidavit - $50.00/per letter

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 (1) Print and Sign Date

____ ______________________________
Parent/Guardian (2) Print and Sign 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 $75 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 Reason 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:____
____

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 ___________________________________
____
____
____

Release of Information

Client Name: ____ Date: ______________________

X________ To be compliant with HIPPA, I 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

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

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 your clinician at any time.

____

Client Name (Printed)

____

If Client Parent/Guardian, Name (Printed)

____

If Client Parent/Guardian, Relationship to Client (Printed)

____

Client or Parent/Guardian 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.

Non-Recording Agreement

Successful therapy depends on building a relationship of trust, good faith, and openness between clients and therapists. Often audio or video recording can inhibit candor and introspection in therapy. Covert recording is a direct violation of trust and good faith to all the other persons in the room.

In addition, recordings made and taken home by clients sometimes fall into unintended hands through loss, random or targeted theft, or action by police, court or governmental agency. Such loss could compromise or nullify your legal expectation of confidentiality in the extremely sensitive personal or interpersonal matters that may have been discussed. Courts may not give your own recordings all the legal confidentiality they give to a therapist's office notes and may find them self-serving. Client recordings can more easily end up becoming an issue in conflicts such as divorce, child custody, or other legal cases or be used by agencies of government. A client who makes a recording solely for personal use or to use against a partner may later be surprised to find the recording being used against him- or herself instead. And once an unfavorable recording exists, its deletion can become legally punishable if a subpoena is issued for it. Additionally, most users of recording technology lack the technological tools and knowledge required to delete a recording in a way that makes it unrecoverable and unhackable.

Factors like these undermine the therapeutic process and the building or rebuilding of trust that takes place between partners in session and between the clients and therapists.

For these reasons and others like them, Therapeutic Impressions, LLC maintains a strict policy on recording.

Therefore, the client signing below agrees that:

1. Recording may only take place with the knowledge and explicit consent of ALL (not just one) clients, therapists, and other persons present during a session or other interaction, whether face-to-face or taking place by live textual, audio, or video link.

2. Consent for each recording must take the form of dated written signatures from all persons on a paper form available for that purpose, with a copy to each person recorded. Additionally, the recording itself must include the live consent of all persons present, with such consent stated at the start of the recording or when they join a session or interaction already in progress.

Therapists at Therapeutic Impressions, LLC will only consent to recording of a session for exceptional reasons and only after the drawbacks and risks have been discussed and the benefit clearly outweighs them.

Violation of this policy by covert recording or non-conformance with this agreement will lead to termination of therapy.

I acknowledge that I have read and understood this policy, accept it, and pledge to uphold it.

____
Client Name (Printed)

____ ______________________________
Client or Parent/Guardian Signature Date

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 Parent/Guardian, Name (Printed)

____
If Client Parent/Guardian, Relationship to Client (Printed)

____
Client or Parent/Guardian Signature

____
Date Notice Received

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapists regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides the therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child will be identified therapy clients with rights of psychological privilege unless a separate written contract is made to conduct family therapy mutually agreed to by the therapist and the parents.

If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record as mandated by law.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession, to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].
-

- Child patients are doing things that could cause serious harm to them or someone else even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused physically, sexually or emotionally – or that it appears that they have been neglected or abused in the past. In this situation, I am [may be] required by law to report the alleged abuse to the appropriate state child – protective agency.

I am ordered by a Court to disclose information with proper releases or other legal exceptions.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of – or might be upset by – but that do not put your child at risk of serious and immediate harm. However, if your child's risk taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

Example: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If your child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would NOT keep this information confidential from you. If your child tells me, or if I believe based on things I learned about your child, that your child is addicted to drugs or alcohol, I would NOT keep that information confidential.

Example: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will NOT keep this information confidential.

You can always ask me questions about the type of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she was doing ________, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of the State of Georgia may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me and you agree not to request access to your child's written treatment records unless ordered by a Court or to transfer the record to another therapist who is serving your child.

As provided elsewhere in this Informed Consent, I do not wish to be involved in the legal system or to speak with anyone regarding testifying in Court. If I am required to testify, I am ethically bound NOT to give my opinion about either parent's custody, visitation suitability, or fitness. Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me for those amounts stated otherwise in this Informed Consent.

Parent/Guardian of Minor Patient:

Please initial after each line and sign below indicating your agreement to respect your child's privacy.

_______ / ________I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

_______ / ________Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment.

_______ / ________I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.

____ ______________________
Parent/Guardian (1) Print and Sign Date

____ ______________________
Parent/Guardian (2) Print and Sign Date