



## Consent for Evaluation and Treatment

### About Bethel Haven

Bethel Haven is a Christian non-profit organization with the purpose of providing help, hope and healing to distressed children, teens, young adults and families through professional therapeutic services. At Bethel Haven, we believe that counseling and therapy provide an individual and/or family a unique opportunity for growth and healing. Bethel Haven's counselors are committed to addressing the needs of the whole person recognizing the biological, social, psychological and spiritual components which make up an individual. A necessary and basic component of counseling and therapy is the collaborative relationship between the therapist and client, and is based upon mutual respect, trust and agreed upon treatment goals. It's important to understand that counseling and therapy have both potential risks as well as potential benefits. Risks may include uncomfortable levels of unpleasant emotions for the individual and/or family, individuals receiving counseling and therapy may feel worse, emotionally, before they begin to feel better, etc.

To get the most from counseling, we believe that it is best if a client can meet with the counselor on a weekly to every other week basis so that too much time does not pass in between sessions. This keeps the relationship open and the therapist and client up-to-date so the focus can remain on the current needs of the client. Depending on the severity of a problem, the counselor may recommend more frequent sessions especially during times of crisis or when dealing with a more complex problem. Clients may participate in short, medium or long-term therapy. Some clients may have a specific, focused problem that is resolved after several months, while others may need counseling and care for longer periods of time. Bethel Haven's goal is to help clients gain the necessary tools and insight so that they may leave stronger, more confident and able to move forward with their lives.

For adult clients, the first appointment is for assessing and understanding the problems for which the client is seeking assistance. For minors, the evaluation process is a two-step process with initial separate appointments with the parent(s)/guardian(s) and the other with the child or teenager. These initial evaluation appointments are important to planning appropriate care and treatment. After the initial evaluation, the therapist will make treatment recommendations and work with the client and/or family to set goals and schedule follow-up appointments. At that time, if a different type of treatment is needed other than which Bethel Haven is able to provide, we will make the appropriate referral or provide the client or family with suitable information for seeking the needed services. Session appointments are 45-50 minutes.

Ultimately, it is Bethel Haven's desire to be an extension of Christ's love to those who are facing various difficulties. We do not discriminate and serve individuals regardless of their religious or non-religious affiliation. We work to understand each client's belief and value systems sharing our own faith as a function of legitimate self-disclosure according to client need. Bethel Haven's approach is "to set apart Christ in our hearts as Lord and always be prepared to give a reason for the hope that is within us, with gentleness and respect, all for the glory of God." (1 Peter 3:15, *paraphrased*)

### Client's Rights & Responsibilities

#### *Participation*

Clients are expected to participate in the planning of their treatment, and they or their guardian(s) have the responsibility to provide accurate information relevant to treatment and/or treatment planning, and follow mutually agreed upon treatment goals. Failure to provide accurate and relevant information as well as follow mutually agreed upon treatment may result in dismissal from treatment. Clients have the right to specify, in advance, the treatment(s) he/she would want/not want in the future should he/she become unable to communicate those wishes. Clients also have the right to refuse treatment and discontinue at any time. However, this is best done in consultation with the provider of care. It is Bethel Haven's desire to work with clients to resolve any grievances that may arise and build upon the therapeutic relationship. Nonetheless, clients have the right to file complaints with freedom from restraint, interference, coercion, discrimination, or reprisal.

## Bethel Haven's Consent for Treatment and Evaluation Continued

### ***Confidentiality***

Trust is an essential part of the therapeutic relationship for both adult and minor clients. However, Bethel Haven's counselors understand that it is necessary to establish an agreement between parents/guardians and youth which clearly defines agreed upon limits of confidentiality. Confidentiality is a privilege protected by law and ethics of the counseling profession that allows for strict private discussion of issues that concern clients. Exceptions include:

- Disclosure to appropriate authorities or family members when there is sufficient cause to believe that a client poses a threat of physical harm to his/her self or others.
- We are required by law to report any form of child neglect or abuse.

In order to provide comprehensive care and emergency coverage for our clients, cases may be shared when needed with our Director or other Bethel Haven on-call therapists. Furthermore, please be aware that another Bethel Haven therapist, counselor, employee or volunteer in the office may answer the phone and may make phone calls to notify and/or remind clients of any appointment changes. All therapists, employees, supervisors and volunteers are required to adhere to Bethel Haven's confidentiality policy.

### ***Informed Consent***

Clients have the right to an explanation of his/her condition and treatment that he/she can understand. Clients have the right to receive sufficient information about proposed and alternative interventions and program goals (and possible risks or consequences of not following recommendations) to enable them to participate effectively. Although Bethel Haven's counselors utilize evidence-based therapeutic approaches, they recognize each client's right to self-determination and individuality and, therefore, cannot guarantee results.

Bethel Haven employs associate therapists that are under supervision according to the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists' rules and Code of Ethics. Currently, Fletcher McClelland, LPC serves at Bethel Haven as Clinical Supervisor for associate therapists who require such supervision while they are seeking full licensure. Bethel Haven adheres to the Code of Ethics outlined by the American Association of Christian Counselors.

### ***Respect & Non-Discrimination***

Clients have the right to be treated with consideration, respect, and full recognition of dignity and individuality regardless of circumstances. Clients have the right to be protected by licensee from neglect; from physical, verbal, and emotional abuse; and from all forms of exploitation. Clients and their parent(s)/guardian(s), have the responsibility to treat staff of Bethel Haven appropriately with consideration and respect.

### ***Reviewing Records***

Each client has the right to review his/her client record as outlined by state law and according to HIPAA regulations.

### ***Keeping Appointments***

We value our clients and the time reserved for each person. Therefore, we require **at least a 24-hour cancellation** notice via phone call. After the first late cancellation (**less than 24-hour notice**) or missed appointment **full session fees** will apply for each late cancellation or missed appointment, as these may prevent another client from being scheduled. Possible termination as a client may also result if behavior is habitual.

### ***Financial Responsibility***

Bethel Haven uses a sliding fee scale based on clients' family size and income, and clients' fees are discussed during the initial evaluation appointment. Please note there are different sliding fees for an individual session versus couple/family sessions. **Fee payment is due at time of service and collected prior to counseling sessions unless other arrangements have been discussed.** Bethel Haven's superbills serve as a receipt of services for clients or guardians to keep for their records and include our NPI number, CPT and ICD codes which may be used when filing for consideration of out-of-network benefits. Please be aware that not all codes are recognized the same by different insurance companies, and Bethel Haven cannot be responsible for ensuring reimbursement and will not change codes for such purposes.

Bethel Haven's Consent for Treatment and Evaluation Continued

In addition to counseling and therapy appointments, Bethel Haven also provides phone consultations, reports and official letters at the request of clients or guardians. Fees for these and other services are outlined below:

- |                                   |                               |
|-----------------------------------|-------------------------------|
| • Phone consultation (15-45 min.) | Fee equals client session fee |
| • Report                          | \$60                          |
| • Official letter                 | \$30                          |
| • Returned check                  | \$25                          |

Therapeutic and support groups are offered from time to time with group session fees dependent on the size and type of group offered.

***Contacting your therapist***

We value our time for each client and meeting their needs, therefore, we have to limit out-of-session communication. We realize there may be times when information may need to be shared prior to a regularly scheduled appointment; therefore we offer clients and/or guardians the options of setting up an appointment or sending a note to be read prior to the session. You are welcomed and encouraged to call the office if there is a major change with you or your child between sessions. We check messages and return phone calls around lunchtime and late afternoon.

Clients or guardians are also responsible for notifying Bethel Haven of any change in address, contact number or other pertinent information important to safe care in a timely manner.

***Emergencies***

If you have an after-hours emergency call (706) 612-8083, and the on-call therapist will return your call as soon as possible. However, for life-threatening emergencies day or night, call 911 or go to the nearest emergency room and ask for a mental health assessment. You can call the following numbers to receive crisis psychological help:

- Advantage Behavioral Health Services 1-800-715-4225
- Suicide hotline 1-800-784-2433 or 1-800-273-8255

**My signature below indicates that I have read, been informed of, and understand the above information and that I give consent for myself or my child to receive counseling and therapy services under these conditions.**

Print name of client: \_\_\_\_\_

Print name & relationship if signing for a minor: \_\_\_\_\_

Signature of client or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices.**

Print name & relationship if signing for a minor: \_\_\_\_\_

Signature of client or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Bethel Haven**  
**Client Information for Minors**

Client's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Does the client currently have health insurance? Yes or No (*please circle*) Name of Insurance Company \_\_\_\_\_

If yes, co-payment, deductible & co-insurance amounts \_\_\_\_\_

Does the client plan to use out-of-network benefits? Yes or No (*please circle*)

\_\_\_\_\_  
Mother/Guardian's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

\_\_\_\_\_  
Father/Guardian's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

Emergency contact information:

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

\_\_\_\_\_  
If client's parents are separated or divorced, please describe who has primary guardianship and visitation & custody arrangements:

\_\_\_\_\_  
Party responsible for payment of services: \_\_\_\_\_

**I acknowledge that the information I have provided above is correct and accurate. I also acknowledge that I will notify Bethel Haven of any changes to this information.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print name and relationship if signing for a minor:** \_\_\_\_\_

**Bethel Haven**  
**New Client Questionnaire**  
 (Children & adolescents under 18 yrs. of age)

**Date:** \_\_\_\_\_

**Personal Data:**

|  |  |                       |  |
|--|--|-----------------------|--|
| Client Name:   |  | Prefers to be Called: |  |
| Age:   | Date of Birth:   | Client's Birthplace:  |  |
| Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Race: <input type="checkbox"/> African-American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other |                       |  |
| Person Completing this form:                                       |  | Relation to client :  |  |

**Reason for visiting:**

Briefly describe your concerns for which you are seeking help at this time:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Approximately when did the problems begin:

Any known stress or event cause or contribute to the problem(s)?  No  Yes (*please describe*):

\_\_\_\_\_

\_\_\_\_\_

Please list your goals/expectations for counseling/therapy: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Client Mental Health History:**

Has the client ever seen a mental health provider for any reason (counselor, psychologist, psychiatrist, etc.)?

| Year | Reason | Name of provider |
|------|--------|------------------|
|      |        |                  |
|      |        |                  |
|      |        |                  |

Results of previous therapy: \_\_\_\_\_

Has the client ever received inpatient hospitalization for a mental health reason?

| Year | Reason | Name of hospital |
|------|--------|------------------|
|      |        |                  |
|      |        |                  |
|      |        |                  |

Has the client ever had any psychological testing?  
 No     Yes *If yes, performed by whom:* \_\_\_\_\_

Has the client ever been diagnosed with ADHD, depression, anxiety, bipolar disorder, schizophrenia, eating disorders, substance abuse, oppositional defiant or conduct disorder, obsessive compulsive disorder or PTSD?  
 No     Yes *(If yes, please describe):* \_\_\_\_\_

Has the client ever threatened or attempted suicide?     No     Yes *(If Yes, please describe):*  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family Mental Health History:**

Has any family member been diagnosed with ADHD, depression, anxiety, bipolar disorder, schizophrenia, suicide, obsessive compulsive disorder, substance abuse or other mental health concerns? If yes, please specify:  
 \_\_\_\_\_  
 \_\_\_\_\_

Please examine the following, and please check any boxes that apply:

| Issue                          | Current Family | Mother's Family | Father's Family | Step-parent's family | Others in the home | Client's previous family |
|--------------------------------|----------------|-----------------|-----------------|----------------------|--------------------|--------------------------|
| Drug abuse                     |                |                 |                 |                      |                    |                          |
| Alcohol abuse                  |                |                 |                 |                      |                    |                          |
| Physical abuse                 |                |                 |                 |                      |                    |                          |
| Emotional abuse                |                |                 |                 |                      |                    |                          |
| Sexual abuse                   |                |                 |                 |                      |                    |                          |
| Multiple moves                 |                |                 |                 |                      |                    |                          |
| Financial strain               |                |                 |                 |                      |                    |                          |
| Parental absence               |                |                 |                 |                      |                    |                          |
| Criminal offenses              |                |                 |                 |                      |                    |                          |
| Eating disorder(s)             |                |                 |                 |                      |                    |                          |
| Death of a close family member |                |                 |                 |                      |                    |                          |

Has a close family member ever attempted suicide or ever been hospitalized in a psychiatric facility?  
 No     Yes *(If yes, please describe):* \_\_\_\_\_  
 \_\_\_\_\_

**Client Medical History:**

Client's doctor: \_\_\_\_\_

Date of client's last physical examination and results: \_\_\_\_\_

Please list all current medications *(including over-the-counter meds, vitamins, herbs, or supplements):*

| Medication name | Dosage | How long prescribed |
|-----------------|--------|---------------------|
|                 |        |                     |
|                 |        |                     |
|                 |        |                     |

Does the client have any drug allergies?  No  Yes (*please list*):  
\_\_\_\_\_

Does the client have any current or chronic medical problems?  No  Yes (*please list*):  
\_\_\_\_\_

If female, age of onset of menses \_\_\_\_\_ Date of last menstrual period \_\_\_\_\_ Are cycles regular?  No  Yes

Exercise habits:  
 Sedentary (no exercise)  Occasional moderate exercise  Regular moderate exercise  
 Occasional vigorous exercise  Regular vigorous exercise

Are you concerned about the client's exercise habits?  No  Yes

Eating habits:  
 Healthy relationship with food  Eat too little  Eat too much  Diagnosed with an eating disorder

Are you concerned about the client's eating habits?  No  Yes

**Client Childhood Development:**

Please describe the pregnancy (include any complications such as illness, injury, prolonged emotional stress, early onset of labor, etc. Also, please include parents' feelings about the pregnancy): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Was the client exposed to any substances such as medications, alcohol, tobacco, environmental toxins, etc during the pregnancy?  No  Yes (*If yes, please list*): \_\_\_\_\_

Birth Weight \_\_\_\_\_ Type of Delivery \_\_\_\_\_ Weeks Gestation at Delivery \_\_\_\_\_

Development Milestones (*answer as best you can recall*)

|   |                                 |                               |                               |
|---|---------------------------------|-------------------------------|-------------------------------|
| Motor Development (sitting, crawling, walking)            | <input type="checkbox"/> Normal | <input type="checkbox"/> Fast | <input type="checkbox"/> Slow |
| Speech & Language   | <input type="checkbox"/> Normal | <input type="checkbox"/> Fast | <input type="checkbox"/> Slow |
| Self-help skills (dressing, brushing, toileting, hygiene) | <input type="checkbox"/> Normal | <input type="checkbox"/> Fast | <input type="checkbox"/> Slow |

Has the client ever receive speech therapy, occupational therapy, etc.?  No  Yes (*If yes, specify*)  
 \_\_\_\_\_

Client is disciplined at home:  frequently  occasionally  rarely

Discipline is administered by (*Check all that apply*)  mother  father  others

What type of discipline is used? (*Check all that apply*)  
 spankings  loss of privileges  restrictions  isolation/time out  talking  rewards

Effectiveness of discipline:  behavior improves  remains same  behavior changes  behavior worsens

Bedtime hour and time of getting up in the morning: \_\_\_\_\_

What are the client's responsibilities at home? \_\_\_\_\_  
 \_\_\_\_\_

**Client's Family Relationships:**

Marital status of parents: *(Please include dates or number of years for all that apply.)*

- married \_\_\_\_\_  separated \_\_\_\_\_  divorced \_\_\_\_\_  
 remarried \_\_\_\_\_  spouse deceased \_\_\_\_\_  living together, but not married \_\_\_\_\_  
 never lived together  single

Client's primary residence:  Single-parent home  Two-parent home  Other \_\_\_\_\_

Currently living with:

- Both bio parents  Bio Father  Bio Mother  Other significant relatives  Other *(explain)*

If parents are separated or divorced, what age was the client when the separation occurred? \_\_\_\_\_

If one or both parents are remarried, what age(s) was the client when the remarriage(s) occurred? \_\_\_\_\_

Siblings/Step-Siblings:

| Name | Age | Lives with | Relationship with client |
|------|-----|------------|--------------------------|
|      |     |            |                          |
|      |     |            |                          |
|      |     |            |                          |
|      |     |            |                          |

Other adults/ non-family members living in the home:

| Name | Age | Relationship with client |
|------|-----|--------------------------|
|      |     |                          |
|      |     |                          |
|      |     |                          |

Please describe visitation and custody arrangements if parents are divorced or separated:

\_\_\_\_\_

If adopted, please describe the circumstances and age of the client at the time of the adoption:

\_\_\_\_\_

If adopted, is the client aware that he/she is adopted:  Yes  No *(If not, reason?)* \_\_\_\_\_

Please describe any bonding or attachment concerns: \_\_\_\_\_

Are there any family problems that may be contributing to your present difficulties? \_\_\_\_\_

**Social History:**

Interaction with peers:

- no friends  few friends  loses friends  many friends  
 trouble making friends  bossy, controlling  too shy or timid  mean, aggressive

When the client chooses friends, they are:

All ages    Younger    Older    Own age    Females    Males    Both males and females

Does the client have a best friend?    No    Yes   What is the age of the friend? \_\_\_\_\_

Is this a supportive friendship or destructive friendship? \_\_\_\_\_

In groups, the client is usually a: leader \_\_\_\_\_ follower \_\_\_\_\_ loner \_\_\_\_\_

What special interests, hobbies, sports and games does the client enjoy? \_\_\_\_\_

If the client is no longer participating in the above activities, what prohibits participation? \_\_\_\_\_

Please list the client's strengths and positive qualities: \_\_\_\_\_

Please list the client's weaknesses or problematic characteristics: \_\_\_\_\_

How would you describe the client as a person, not just as a son or daughter? \_\_\_\_\_

How does the client describe him/herself? \_\_\_\_\_

Have family members, friends, teachers or others ever characterized the client as being:

- |   |  |   |  |   |
|---|--|---|--|---|
| <input type="checkbox"/> Humorous       | <input type="checkbox"/> Fun to be around      | <input type="checkbox"/> Cheerful         | <input type="checkbox"/> Restless                        | <input type="checkbox"/> Inattentive    |
| <input type="checkbox"/> Shy            | <input type="checkbox"/> Abusive               | <input type="checkbox"/> Sneaky           | <input type="checkbox"/> Creative                        | <input type="checkbox"/> Quick to anger |
| <input type="checkbox"/> Daydreamer     | <input type="checkbox"/> Untruthful            | <input type="checkbox"/> Nervous/Tense    | <input type="checkbox"/> Aggressive                      | <input type="checkbox"/> Hard Worker    |
| <input type="checkbox"/> Immature       | <input type="checkbox"/> Friendly              | <input type="checkbox"/> Talented         | <input type="checkbox"/> Disruptive                      | <input type="checkbox"/> Resilient      |
| <input type="checkbox"/> Forgetful      | <input type="checkbox"/> Mature for age        | <input type="checkbox"/> Fearful          | <input type="checkbox"/> Disobedient                     | <input type="checkbox"/> Imaginative    |
| <input type="checkbox"/> Stubborn       | <input type="checkbox"/> Mean to others        | <input type="checkbox"/> Sad              | <input type="checkbox"/> Messy                           | <input type="checkbox"/> Worrier        |
| <input type="checkbox"/> Cruel          | <input type="checkbox"/> Unmotivated           | <input type="checkbox"/> Loud             | <input type="checkbox"/> Careless                        | <input type="checkbox"/> Helpful        |
| <input type="checkbox"/> Lazy           | <input type="checkbox"/> Gives up easily       | <input type="checkbox"/> Motivated        | <input type="checkbox"/> Sweet                           | <input type="checkbox"/> Quiet          |
| <input type="checkbox"/> A complainer   | <input type="checkbox"/> A leader              | <input type="checkbox"/> Lacks Confidence | <input type="checkbox"/> Rambunctious                    | <input type="checkbox"/> Kind           |
| <input type="checkbox"/> Conscientious  | <input type="checkbox"/> Considerate           | <input type="checkbox"/> Insecure         | <input type="checkbox"/> Criticizes others               | <input type="checkbox"/> Uncaring       |
| <input type="checkbox"/> Can be trusted | <input type="checkbox"/> Doesn't complete work |   | <input type="checkbox"/> Jealous of brother(s)/sister(s) |   |

Has the client experienced or witnessed physical abuse, sexual abuse, or neglect?

No    Yes   (*If yes, please briefly describe*): \_\_\_\_\_

Is the client sexually active?    No    Yes

Is the client currently using or had a history of using tobacco, alcohol, or illicit drugs?

No    Not sure    Suspect    Yes   (*If yes, frequency, drug name, amount, etc*): \_\_\_\_\_

Client history of legal charges or probation:    No    Yes   (*If yes, please explain*): \_\_\_\_\_

**School/Work History:**

|   |              |
|---|--------------|
| Name of school: _____   | Grade: _____ |
| Grades Repeated, if any: _____ Any learning problems/disabilities? _____        |              |
| Please check the box for all that apply and explain the grades related to each. |              |
| <input type="checkbox"/> Had extended or frequent illness(es): _____            |              |
| <input type="checkbox"/> Had to repeat a year: _____                            |              |
| <input type="checkbox"/> Skipping school: _____                                 |              |
| <input type="checkbox"/> Changed schools mid-year: _____                        |              |
| <input type="checkbox"/> Began school year at a new school: _____               |              |
| <input type="checkbox"/> Had conduct problems: _____                            |              |
| <input type="checkbox"/> Other _____  |              |
| How does the client feel about school, teachers and peers?<br>_____<br>_____    |              |

**Spiritual History:**

|   |
|---|
| Is spirituality, religion or faith important in the client's life? <input type="checkbox"/> No <input type="checkbox"/> Yes   |
| Spiritual affiliation: <input type="checkbox"/> None <input type="checkbox"/> Christian <input type="checkbox"/> Other ( <i>please specify</i> ): _____                     |
| Please describe the client's participation in spiritual activities ( <i>i.e. prayer, church attendance, youth group, etc.</i> ):<br>_____                                   |
| If applicable, please specify which church, temple, synagogue you attend: _____   |
| Does the client believe in God? <input type="checkbox"/> No <input type="checkbox"/> Yes ( <i>If yes, please describe his/her relationship with God</i> ):<br>_____         |
| Was the client raised in a spiritual or religious tradition? <input type="checkbox"/> No <input type="checkbox"/> Yes ( <i>If yes, please describe</i> ): _____             |
| Does the client practice in the tradition in which he/she was raised? <input type="checkbox"/> No <input type="checkbox"/> Yes ( <i>If yes, please describe</i> ):<br>_____ |
| When the client has religious/spiritual concerns and problems, who does he/she talk to? _____   |
| Does the client have a specific spiritual concern that is causing any known distress at this time? _____  |

|  |
|--|
| Is there anything else we did not ask that you feel would be helpful for your counselor to know? _____<br>_____<br>_____ |
|--|

**Please review the following list of symptoms and check all that apply:**

Sleep Pattern: Please describe if the client has problems with sleep such as frequent awakenings, nightmares, sleeping too much/not enough, sleep apnea, snoring, etc. \_\_\_\_\_ Average # of hrs/night \_\_\_\_\_

Appetite changes: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Weight loss or Weight gain: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Fear of weight gain, purging, bingeing, restricting food, misuse of laxatives, etc.: No \_\_\_ Yes \_\_\_ Describe \_\_\_\_\_

Mood Swings: No \_\_\_ Yes \_\_\_ Describe \_\_\_\_\_

Loss of pleasure of previously enjoyed activities: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Fatigue or loss of energy: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Feelings of worthlessness or inappropriate guilt: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Depression: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Recurrent thoughts of death or thoughts of suicide: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Cutting or other self-harm: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Hearing voices or seeing things that others do not see: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Odd beliefs that others do not believe: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Recent concerning behavioral changes: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Unrealistic Fears/Worries: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Panic Attacks: No \_\_\_ Yes \_\_\_ (*Circle symptoms*) Shortness of breath, chest pain, racing heart, feeling of choking or dying, flushing

Time consuming rituals: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Distressing obsessive thoughts/compulsions: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Social concerns: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Any emotional trauma or recent loss: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Racing thoughts, inflated self-esteem, decreased need for sleep or participation in activities that have a high potential for painful consequences that are out of normal character (i.e. spending sprees, sexual indiscretions, substance abuse):  
No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Aggression/Anger: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Unexplained Headaches or Stomach Aches: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Focus/Concentration problems: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Hyperactivity/Impulsivity: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Alcohol consumption: No \_\_\_ Yes \_\_\_ If yes, list frequency and amount: \_\_\_\_\_

Marijuana use: No \_\_\_ Yes \_\_\_ If yes, list frequency and amount: \_\_\_\_\_

Other drug use: No \_\_\_ Yes \_\_\_ If yes, list substance, frequency and amount: \_\_\_\_\_

Addictions (pornography, food, internet, substances, etc.): No \_\_\_ Yes \_\_\_ If yes, Describe: \_\_\_\_\_

Defiance: No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Bedwetting or daytime wetting: \_\_\_ Yes \_\_\_ If yes, how often? \_\_\_\_\_

Fecal soiling of clothes: No \_\_\_ Yes \_\_\_ If yes, how often? \_\_\_\_\_

Lying, stealing, destroying property, initiating fights, cruelty to children/animals, or sexually acting out behaviors towards others:  
No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

**Bethel Haven**  
**Sliding Fee Scale for 45-Minute Counseling Session**

**Please circle the income range corresponding to the size of the family unit.**

Income reported should include alimony, child support and/or SSI. For young adult clients, who are still dependents of a parent/guardian, (s)he should report the family income of the parent/guardian claiming them. If you do not wish to report this information, Bethel Haven's standard counseling rates will apply.

| Family Size | Annual Gross Household Income |                     |                     |                      |                       |                 |
|-------------|-------------------------------|---------------------|---------------------|----------------------|-----------------------|-----------------|
|             | A                             | B                   | C                   | D                    | E                     | F               |
| 1           | < / = \$14,000                | \$14,001 – \$19,000 | \$19,001 – \$30,000 | \$30,001 – \$43,000  | \$43,001 – \$54,000   | > / = \$54,001  |
| 2           | < / = \$20,000                | \$20,001 – \$26,000 | \$26,001 – \$40,000 | \$40,001 – \$59,000  | \$59,001 – \$73,000   | > / = \$73,001  |
| 3           | < / = \$25,000                | \$25,001 – \$32,000 | \$32,001 – \$51,000 | \$51,001 – \$74,000  | \$74,001 – \$92,000   | > / = \$92,001  |
| 4           | < / = \$30,000                | \$30,001 – \$39,000 | \$39,001 – \$61,000 | \$61,001 – \$89,000  | \$89,001 – \$112,000  | > / = \$112,001 |
| 5           | < / = \$35,000                | \$35,001 – \$45,000 | \$45,001 – \$72,000 | \$72,001 – \$105,000 | \$105,001 – \$131,000 | > / = \$131,001 |
| 6+          | < / = \$40,000                | \$40,001 – \$52,000 | \$52,001 – \$82,000 | \$82,001 – \$120,000 | \$120,001 – \$150,000 | > / = \$150,001 |

*1st Time New Client Evaluation = Regular sliding fee amount + \$25.00 new client fee*

**I verify that the above information I have provided is correct, and understand fees are due at the time services are rendered. I also may be asked to verify evidence of income by paystub or W2 form.** (Clients will be asked to update this information annually at the beginning of each calendar year.)

**Client Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print name and relationship if signing for a minor** \_\_\_\_\_

|  |
|--|
| <p><b><u>Office Use Only</u></b></p> <p>Individual Counseling Fee: _____</p> <p>Couples/Family Counseling Fee: _____</p> |
|--|

## Updated September 2013

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information (PHI). Commonly referred to as “medical records privacy law,” HIPAA provides patient protections related to the electronic transmission of data; the keeping and use of patient records; and storage and access to health records. HIPAA applies to all health care providers, including mental health care and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You have already received similar notices as this one from your other health care providers.

As you might expect, HIPAA laws and regulations are extremely detailed and confusing if one does not have formal legal training.

### Georgia HIPAA Notice

Notice of Therapists/Counselors’ Policies and Practices to Protect the Privacy of Your Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Georgia State Laws.

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION UNDER THE NEW HIPAA LAWS. PLEASE REVIEW IT CAREFULLY.

#### **I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

We may use or disclose your protected health information (PHI) for treatment, payment and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations” is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist/counselor.
- “Payment” is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- “Health Care Operations” are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities in our office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- “Disclosure” applies to activities outside of our office such as releasing, transferring or providing access to information about you to other parties.
- A health plan that intends to use or disclose PHI for underwriting purposes is prohibited from using or disclosing genetic information for underwriting purposes.
- The disclosure of PHI is restricted (for payment or health care operations) to a health plan when the patient paid for the service or item in question out of pocket in full.

#### **II. Uses and Disclosures Requiring Authorization**

We may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. “Psychotherapy Notes” are notes that we have made about our conversation during a private, group, joint or family counseling session, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, as the law provides the insurer the right to contest the claim under the policy.

- Most uses and disclosures of psychotherapy notes will require authorization.
- Uses or disclosures of protected health information for marketing purposes will require authorization.
- The sale of protected health information (PHI) requires authorization.

#### **III. Uses and Disclosures with Neither Consent nor Authorization**

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Serious Threat to Health or Safety** – If we determine, or pursuant to the standards of our profession should determine, that you present serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.
- **Child Abuse** – If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.
- **Adult and Domestic Violence** – If we have reasonable cause to believe that an adult with a disability or elder person has had a physical injury or injuries inflicted upon such adult with a disability or elderly person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authorities.
- **Health Oversight** – If we are the subject of an inquiry by the Georgia Board of Examiners, we may be required to disclose PHI regarding you in proceedings before the Board.
- **Judicial or Administrative Proceedings** – If you are involved in a court proceeding and a request is made about the professional services we provide you or the records thereof, such information is privileged under

state law, and we will not release information without written consent from involved parties or court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Worker’s Compensation** – We may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.
- **Fundraising** - You have the right to opt out of receiving fundraising communications.

#### **IV. Patient’s Rights and Therapist/Counselor’s Duties**

##### **Patient’s Rights:**

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of PHI. However, we are not required to agree to a restriction that you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are in treatment. On your request, we will send your bills to another address to your choosing.)
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. An appointment will be scheduled to review these records in our presence so that any issues can be discussed. Normal hourly and/or copying charges will apply. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. Upon your request, we will discuss with you the details of the amendment process.
- **Right to Accounting** – You generally have the right to receive an accounting of disclosures of PHI. Upon your request, we will discuss with you the details of the accounting process.
- **Right to Paper Copy** – You have the right to obtain a paper copy of the notice from us upon request.
- **Breach Notification**-You have a right to know when a breach of your unsecured PHI has occurred.

##### **Therapist/Counselor’s Duties:**

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will notify you at the mailing address you provided.

#### **V. Complaints**

If you are concerned that we have violated your privacy rights, or you disagree with a decision that we made about access to your records, you may contact us at (706) 310-9046 or via U.S. mail at 1030 Village Dr. Suite B, Watkinsville, GA 30677. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We can provide you with the appropriate address upon your request. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

#### **VI. Restrictions**

We will limit the uses or disclosure that we will make as follows:

- We will not release contents of “Psychotherapy Notes” under any circumstance with the following exceptions:
  - If you file a lawsuit or ethics complaint against us, we may release “Psychotherapy Notes” for use in our defense.
  - When the following “Uses and Disclosures with Neither Consent nor Authorization” apply:
    - Child Abuse
    - Adult and Domestic Abuse
    - Health Oversight
    - Judicial or Administrative Proceedings
    - Serious Threat to Health or Safety

# Important Notice for All Clients

## Missed Appointment Policy

We value our clients and the time reserved for each person. To ensure availability is managed appropriately, it is necessary for us to have the following policy for missed appointments:

### First Missed Appointment

Due to unforeseen circumstances or human forgetfulness, Bethel Haven will **not** charge for the first missed appointment. At which point, Bethel Haven's policy will be reviewed with you.

| Missed Appointments After First:  |  |
|---|--|
| Notice given within a four hour window of appointment<br><b>HALF OF SESSION FEE CHARGED</b> | No Advance notice<br>(No call, no show)<br><b>FULL SESSION FEE CHARGED</b> |

*\*Missed appointments without a given notice lowers the quality of care we can provide to clients. Each therapy session is specifically reserved and cannot be offered to anyone else. Because of this fact and Bethel Haven's commitment to quality and timely services, we have implemented this policy to ensure availability for all. Clients will not be billed or invoiced late fees. The card information below will be used to charge the client's account. A receipt may be generated at the client's request. Please fill out the information below. Your signature only authorizes Bethel Haven to charge your account strictly under the listed circumstances alone.*

|                                |                  |                   |
|--------------------------------|------------------|-------------------|
| First Name:                    | Last Name:       | E-mail:           |
| Card #:                        | Expiration Date: | CVV code on back: |
| Zip Code associated with card: | Card Type:       |                   |
| Date:                          | Signature:       |                   |