TRANSFORMATIONS
THERAPY OF ATLANTA

770-217-7563 office

CLIENT INTAKE PACKET

www.transformationsatl.com

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Information, Authorization and Consent to Treatment

**Please initial next to each section on this form and sign and date on the last page*

Welcome to Transformations Therapy of Atlanta! We are pleased that you have chosen our agency to help you with your clinical needs. The purpose of this form is to inform you of our policies and protocols as well as to help you greater understand what you can expect during treatment. Though we have an ethical obligation to provide this information to you, it is important that you know that we will work closely with you throughout the entire process, welcoming any feedback or suggestions you may have.

_____Services Provided
Transformations Therapy of Atlanta only offers in office psychotherapy and tele mental health services via telephone or video sessions. Due to the nature of tele mental health clients must review and sign our tele mental health consent form which details the nature of tele mental health. Individual and couples therapy are provided during the tele mental health sessions.

_____Our Approach to Treatment
Transformations Therapy of Atlanta works closely with clients to develop a treatment model that suits their individual needs. Depending on the specific needs of the client, we may employ a psychodynamic, behavioral, cognitive or dialectical approach or a combination of these modalities. Clients are always informed of the type of approach being employed during the course of treatment. The client has the right to request a different type of approach. We will only practice within our scope of expertise, skill or training and should a client prefer to employ a specific modality where the therapist is not skilled, the therapist will notify the client of this and offer to provide an appropriate referral. We believe in not only treating the surface symptoms of clients which could be emotional or behavioral or a combination of both but also in helping the client to gain a greater understanding of the underlying reasons for the emotions or behaviors.

_____Client Participation
It is our belief that therapy is most successful when the therapist and client are committed to work together as a team toward common goals. It is important that the client understand the need to be open and honest during the sessions as the therapist will only be able to use the information provided to develop a proper treatment plan. When clients withhold information related to their history, thoughts or current situations in their lives, successful outcomes can be delayed or even damaged. The greater effort placed into employing learned techniques and skills outside of therapy, the greater the chance of achieving your desired treatment goals. It should be noted that during therapeutic treatment, the client may feel worse before they actually begin to feel better. We attribute this to the process of dealing with issues that may not have been addressed for quite some time. For this reason, it is absolutely necessary for the client to be committed to the process of therapy.

_____Confidentiality
Transformations Therapy of Atlanta will take every effort to maintain confidentiality of your PHI (protected health information). Details and exclusions to this is detailed in our Notice of Privacy Practices which is required to be reviewed and signed by you. We maintain all of your clinical records in a secure HIPPA compliant database. All of our video sessions are held via a HIPPA complaint video software unless consented to otherwise by the client. We will only release information of your records with your consent. If we feel the need to collaborate with other professionals regarding your treatment, we will notify you and have a release of information form signed by you prior to any communication. During our couples

counseling sessions, it is understood that both partners are considered clients of the therapist, therefore all information provided by either party, even during separate sessions are considered part of the couples therapy. In other words, therapist will not withhold any information provided by one partner from the other partner.

It is understood that therapist will make every effort on her end to protect private health information during a telephone call or video session and client is expected to make every effort to maintain confidentiality of the session. Please refer to the tele mental health consent form for more details.

Your therapist may breach confidentiality if she deems you are in danger of harming yourself or others or if there is a report of abuse to an elder or to a child.

Information shared during your therapy sessions are considered 'privileged communication' and the state of Georgia often upholds this right. However, there are certain circumstances that a judge may subpoena your records at which time every effort will be made to appeal this decision. However, if law mandates even after an appeal, we must release your PHI. It is important that the client understands and agrees to not involve their therapist in any legal matters.

_____Session Format
All sessions are held in office or via telephone or HIPPA compliant video format. Clients requesting telephone session must understand that therapist reserves the right to require video or in office sessions during the treatment process. In order to provide the most effective treatment possible, clients will not be allowed to only have phone sessions. Telephone sessions may be incorporated along with regular video or in office sessions. The cost for sessions varies, please visit our website at www.transformationsatl.com for a complete list of pricing.

_____Cancellations and No Show's
Clients are expected to provide at least a 24 hour cancellation notice prior to the time of your scheduled appointment. Cancellations received less than 24 hours of your scheduled appointment will incur a fee of $75. This fee will be charged to the credit card on file at the time of cancellation. Should the card be declined, client will not be allowed to reschedule until the balance is paid. In the event of emergent situations, therapist reserves the right to waive a late cancel; this late cancel waiver is determined by the therapist and only allowed to be applied to the client's account once. Multiple consecutive cancellations could result in termination of services, see terminations section of this form. Clients who do not call to cancel their appointment or to reschedule, will be charged a fee of $75. No Show's will not be permitted a one-time waiver.

_____Emergency Situations
Transformations Therapy of Atlanta is not accessible to clients 24 hours per day. Typically, your call to your therapist should be returned within a 24-48 hour period. If it is a holiday or weekend, your call may be returned the next business day. In the case of an emergency, please call 911 or dial the Georgia Crisis and Access Line at 1-800-715-4225.

_____Professional Relationship
Your therapist will conduct themselves in a professional manner at all times during therapeutic sessions. It is expected that the client will conduct themselves in a professional manner as well. Due to the rapport and trust building involved in the disclosure of personal information during therapeutic sessions, it can be easy to misconstrue a therapeutic relationship to be a form of friendship. Your therapist cannot engage in any activities with you outside of therapy sessions, including but not limited personal phone calls or text messages, social media engagement through personal social media sites. Your therapist cannot engage in or accept any romantic gestures by the client. Your therapist cannot accept gifts from the client. The only time a therapist may have contact with you through social media is through that therapist's business social media page and all communications via that social media site must remain

professional. Should you encounter your therapist in public, they are required to keep your identity confidential by not acknowledging that they know you. However, if you initiate contact and/or communication with your therapist in a public setting, they will engage. All of the above precautions are detailed to preserve the integrity of the therapeutic relationship and avoid any conflict of interest or presentation of a dual relationship between the therapist and the client.

_____Completion of Paperwork
Clients understand that any requests for completion of paperwork related to but not limited to disability claims, FMLA and other related paperwork may be completed at the discretion of the therapist. If the therapist agrees to complete such paperwork, there will be a fee of $15 per 10 minute increment charged to the clients account.

_____Legal Involvement
Client understands that the therapist reserves the right to refuse clients who initially disclose the possibility of legal involvement and not become involved in any legal matters unless ordered by a signed subpoena. If a therapist refuses services during the initial appointment, a referral for another therapist will be provided to client.

_____Termination of the Therapeutic Relationship
Ideally, we would like for all of our therapeutic relationships to end when the client's treatment goals are achieved. However, we understand this is not possible at all times.

Clients are able to terminate therapy at any time, they are encouraged to choose a therapist with whom they feel comfortable and able to trust. If at any time, you feel uncomfortable or unable to trust your therapist, it is highly encouraged for you to discuss these concerns with your therapist.

If you feel your therapist, is not meeting your therapeutic needs, it is encouraged for you to discuss this with your therapist to work to resolution. If no, resolution can be made, please notify your therapist as they may be able to provide you with a referral.

If you decide to terminate therapy, we ask that regardless of your reason, you communicate this with your therapist. Some therapists, may want to schedule a final session with you in which you have the option to decline.

A therapist can terminate your sessions if they feel their services and skill are not sufficient to meet your treatment needs. At this time, a referral will be made.

A therapist can terminate the session, if they evaluate the clients actions to be inappropriate and/or damaging to the therapeutic relationship (i.e., not respecting the boundaries of the therapeutic relationship). At this time, a referral will be made.

A therapist can terminate a session, if a client cancels three or more consecutive appointments or no show's to one appointment and does not respond after a follow up call made by the therapist.

_____
Client Signature and Date

_____
Therapist Signature and Date

**Therapist signature indicates that this form has been reviewed with you and any questions regarding the form have been answered.*

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4566 Lawrenceville Hwy Ste101
Lilburn, GA 30047
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HIPPA Notice of Privacy Practices
Effective Date 3/1/17

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

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, and on my website. The website will always have the most recent version.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.**

2. **To obtain payment for your treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.**

3. **For health care operations. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws**

Certain Uses and Disclosures Require Your Authorization.

1. **Psychotherapy Notes. I do not keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501; rather, I keep a record of your treatment and you may request a copy of such record at any time, or you may request that I prepare a summary of your treatment. There may be reasonable, cost-based fees involved with copying the record or preparing the summary.**

2. **Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes. Marketing is defined as receiving financial remuneration for communicating about other businesses 'health-related services or products to patients.**
3. **Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.**

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations mandated by law, I can use and disclose your PHI without your Authorization for the following reasons:

1. **When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.**
2. **For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.**
3. **For health oversight activities, including audits and investigations.**
4. **For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.**
5. **For law enforcement purposes, including reporting crimes occurring on my premises.**
6. **To coroners or medical examiners, when such individuals are performing duties authorized by law.**
7. **For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.**
8. **Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.**
9. **For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.**
10. **Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.**

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.**

YOUR RIGHTS YOUR REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.**
2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.**

3. **The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.**
4. **The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.**
5. **The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.**
6. **The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.**
7. **The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.**

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES
If you think your privacy rights may have been violated, you may file a complaint to the owner of Transformations Therapy- Tia Thomas (address and telephone number are at the beginning of this document).

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:
1. **Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;**
2. **Calling 1-877-696-6775; or,**
3. **Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.**

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE
3/1/17

_____
Client print name

_____
Client signature and date

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Client Intake Form

Please complete and submit prior to your initial appointment, if possible

Name: _____
(First and Last)

Name of Parent/Guardian: (For children 17 and younger)

_____

Date of Birth: _____ Marital Status: ___Single ____ Married ____Divorced ___Widowed

Address: _____

Contact Number: _____

Alternate Contact Number:_____

Email Address: _____

Referral Source: _____

Emergency Contact: (Name and Number) _____

Briefly describe why you are seeking counseling: _____
_____
_____
_____
_____
_____
_____
_____

When did these problems begin? _____
_____
_____
_____

Have you ever had counseling before? If so, give dates, reasons for counseling and outcome: ___
_____
_____
_____
_____
_____

Have you ever been hospitalized in a psychiatric facility? If so, give dates and reason for admission: _
_____
_____
_____
_____

Have you ever had suicidal thoughts, plans or attempts? If so, give dates of last thought/plan and list all attempts: _____
_____
_____
_____

Have you ever had incidents of self-harm (cutting, scratching, burning, hair pulling, hitting, etc.)? If so, please explain: _____
_____
_____
_____

Do you have any family history of mental illness (maternal or paternal)? If so, please list and specify: _
_____
_____
_____
_____

Do you have any diagnosed mental health or medical conditions? If so, please list all diagnosis and list any prescribed medications. _____
_____
_____
_____

Please provide the name and contact number for your Primary Care Physician and/or Psychiatrist: ____
_____
_____
_____

Do you feel you have an adequate support system? If so, please discuss who is in this system: _____
_____
_____
_____
_____

Have you experienced any trauma (abuse, major life changes, divorces, break ups, etc.) If so, please explain: _____
_____
_____
_____
_____
_____

Where are you employed? _____ How long? _____

What are your hobbies or any organizations in which you are involved? _____

What are your self-care strategies/ habits? _____

Do you have any current and/or history of substance abuse (alcohol, recreational drugs)? If so, please list amount and frequency: _____

Do you have any unresolved issues from childhood that could be affecting your presenting issues? If so, please specify: _____

Discuss your desired treatment goals/outcomes: _____

What is your schedule availability? Desired appointment days/times: _____

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Telemental Health Consent Form

Client hereby consents to engaging in telemental health psychotherapy counseling. Client understands that this includes the practice of diagnosis, psychotherapy delivery, consultation, treatment, transfer of clinical data (when necessary and with consent), and education using interactive audio, video, or data communications.

Client attests to providing accurate identifying information such as name, date of birth, and address as well as accurate contact and emergency contact numbers and agrees to the use of this information in the event of an emergency.

Delivery of Services

1. Services will be delivered in a professional manner; therapist and client agree to conduct themselves in a respectful manner during the counseling sessions.
2. Client understands that they may benefit from telemental health counseling, but that results cannot be guaranteed or assured

Confidentiality

The following is understood in regards to the delivery of telemental health counseling:

1. Therapist cannot guarantee confidentiality of sessions during telephone sessions. However, therapist will make every effort on their part to ensure confidentiality is met by not allowing any third party present during these sessions without written consent of client. Client understands that they are responsible for ensuring confidentiality of the sessions on their end by not placing the call on speaker or allowing third parties to be present during the call. Should the client allow this to occur, they understand that therapist is not responsible for any breach of confidentiality.
2. Therapist will ensure no other parties are present during the time of scheduled sessions to uphold confidentiality. Client agrees to make every effort to ensure no third party is present during video conferencing sessions. Should the client allow a third party to be present during these sessions, they understand that therapist is not responsible for any breach of confidentiality.
3. Client understands that there are risks and consequences with telemental health counseling, including, but not limited to, the possibility, despite reasonable efforts on the part of the psychotherapist, that: the transmission of clinical information could be disrupted or distorted by technical failures; the transmission of clinical information could be interrupted by unauthorized persons; and/or the electronic storage of clinical information could be accessed by unauthorized persons.
4. This form is an addendum to the HIPPA and Informed Consent Form which shall be agreed to and signed by the client.

Scheduling

1. Sessions will be scheduled either by phone or online.
2. Session times will be selected upon appointment scheduling; Sessions will end approximately five minutes prior to the end of the session to allow time to schedule the next appointment and for proper clinical documentation.

Payment for Services

1. Payment for telemental health services will be in the form of credit or debit card; mailed in cash payments are not accepted. Partial payments are not accepted
2. Client will provide a valid credit or debit card when scheduling the initial session which will be saved on a secure website and charged prior to the start of each session.

Late Cancellations

1. Clients understand that they will be charged a $75 late cancellation fee if an appointment is cancelled less than 24 hours of the scheduled appointment time.
2. Clients understand that the credit or debit card on file will be charged this late cancel fee at the time of the missed appointment.

Termination of Telemental Health Services

Therapist providing telemental health services reserves the right to terminate telemental health services and request in office sessions should any of the following occur:

1. Therapist assesses safety issues such as reports of suicidal thoughts or homicidal thoughts.
2. Therapist assesses that telemental health services are not meeting the needs of the client and that these needs would be best met with in office sessions
3. Therapist assesses inappropriate behavior on part of the client during the telemental health sessions.
4. Therapist discovers new diagnostic or any other unreported history during the telemental health sessions in which he/she feels the need to require in office sessions.
5. Client cancels more than three consecutively scheduled appointments prior to the 24 hour period or has two consecutive late cancellations

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____ _____

Client Signature and date Therapist Signature and date

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Payment Consent Form

Name on Card: _____
(This should be patient name)

If not, please provide patient name: _____

If name on card is different from patient name, please provide your relationship to the patient and your contact information (phone and address): _____
_____
_____

This form must be completed and signed by the person authorizing payment and whose name appears on the card.

I authorize, Transformations Therapy of Atlanta, LLC to charge my card for the following:

1. **All Psychotherapy sessions rendered; fee is determined by the length of the session; pricing is available on our website.**
2. **Any late cancellation fee or no show fee; the equivalent of $75**
3. **Any unpaid balances related to services rendered or missed sessions**

I have provided Transformations Therapy with the following card number to cover the cost of treatment as detailed above.

Card number ending in _____ (last four digits)
___Visa ___MasterCard ___Discover___American Express

You may provide this card to your therapist directly or enter the information on the secure client portal. Your credit card information will be saved on the encrypted client portal site for your privacy.

_____
Signature of Authorizing Person and Date

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Insurance Agreement

This form is to notify you of the circumstances surrounding the filing of insurance claims for mental health services.

Many insurance companies will require for mental health professionals to release certain details related to sessions in order to pay for the services rendered. This information can include health information, treatment goals and progress and related information to support the goals and assessment of progress.

It is understood that you agree to allow the therapist to provide related information regarding your treatment to insurance agencies in order to receive reimbursement.

It is also understood that it is your responsibility to verify your benefits, including copayment and deductibles.

If any portion of a claim is returned unpaid by an insurance company, it is understood that the client is responsible for payment of this balance. Therapist will notify client of the unpaid balance and the card on file will be processed for the amount due, unless the client provides therapist with an alternate form of payment.

It is your responsibility to make sure you update your therapist on any changes to your insurance information.

Please provide the following regarding your insurance along with a copy of your insurance card (back and front):

Primary insurance company:_____

Phone number: _____

Address to mail claim: _____
_____

Name of Insured: _____

ID Number:_____

Group Number: _____

Employer Information (For primary insured)

Name: _____

Address:_____

Relationship to insured: ___ **self** ____**parent/guardian**

_____
Client printed name and date

_____
Client Signature and date

_____
Parent/Guardian Signature if applicable