**Welcome!**

Please review the following documents carefully and complete the following paperwork in full.

Any questions that arise can be discussed in our upcoming session.

I look forward to meeting you and working together.

Thank you,

Tara Arnold, PhD, LCSW

**Client Contract**

Welcome to my practice. I am so glad that you are here. Contained within is essential information about my practice and psychotherapy. Please read, initial where necessary, and sign the bottom to indicate that you have reviewed this information.

**Professional Credentials and Licensing Regulations**: I am a Licensed Clinical Social Worker who holds a PhD in Social work. In addition, I am a certified eating disorder specialist with the International Academy of Eating Disorder Professionals.

**Length and Frequency of Treatment**: Psychotherapy typically involves regular sessions, usually 45 minutes in length. As part of our work together, you and I will decide how long and how often we will meet. Duration and frequency may vary, however, depending on the nature of your problem and individual needs.

**Confidentiality**: Information you share with me will be kept strictly confidential and will not be disclosed without your written consent. By law, however, confidentiality is not guaranteed in life threatening situations involving yourself or others, or in situations in which children and vulnerable adults are at risk, such as sexual or physical abuse or neglect.

I will be legally required to release records of clients when a court order has been placed.

If I need to discuss your treatment with a colleague I will disguise identifying information including using a pseudonym.

If necessary, Billing information will be shared with my billing company in order to obtain insurance reimbursement.

**Fee Policies**: My fee is $235 per session. There is a cash discount, making my fee $230, for payments made with cash or check. I currently do not accept insurance; however, I can provide you with a superbill to submit to your

**Client Contract**

insurance company for reimbursement. You are responsible for the $235 session fee regardless of reimbursement, so it is important that you call your insurance carrier to verify your out of network coverage for behavioral and mental health services. If your bill becomes delinquent and your account is sent to collections or you have a returned check, you will also be responsible for the collection agency fee and/or the additional banking fees. Please initial here: \_\_\_\_\_\_\_\_\_

If you need to cancel an appointment, please call me at least 24 hours ahead of time, otherwise I will charge you my full fee of $235 for the missed session. Please initial here: \_\_\_\_\_\_\_\_\_

I have a limited number of spaces in my practice for patients who need to negotiate a reduced fee. If this applies to you and if I have space available at the time, we will discuss and agree on a fee and sign a reduced fee contact. Please note the initial assessment will be charged at my standard fee.

**Phone and Emergency Contact**: If you need to contact me by phone, do not hesitate. Please call 404-964-6629. When I am not available, please leave a message on my confidential voicemail. I am usually able to return calls within the day. You will be charged for phone calls that last more than 10 minutes. Phone sessions will be indicated as such on receipts and are not usually reimbursed by insurance and are charged my same fee as indicated above.

If you are experiencing a life-threatening emergency (defined as harm or risk of harm to yourself or someone else), please do not hesitate to call 911, go to your nearest emergency room, or call your county mental health crisis line. The telephone numbers for the local mental health crisis lines are DeKalb 404-892-4646, Gwinnett 770-985-2494, and Fulton 770-730-1600.

Phone and text communication is to be used for appointment confirmation only, and it should not be used to express clinically relevant material best discussed in session.

**Rights and Responsibilities**: You have the right to be treated with respect, you have the right to be informed about your treatment, and you have the right to be informed about your confidentiality and the limitations of confidentiality. You have the right to end therapy at any time without penalty, and if you wish to do so I will provide you the names of other qualified psychotherapists. You have the right to ask questions and voice concerns. You have the responsibility to attend and participate in therapy. Participation includes formation of goals and communicating with me regarding your concerns. You have the responsibility to pay for sessions and to pay the late cancellation or missed appointment fee if you no show or cancel with less than 24-hour notice.

**Social Media Policy**: Due to the nature of the psychotherapy relationship, I will not be able to have any personal contact via social media such as being personal Facebook friends, following on Twitter, Instagram, etc. There are some group formats that involve less direct that may be permissible; however, in making the decision to join, it is with your knowledge that confidentiality cannot be guaranteed on a third party format.

**Informed Consent**: I have read and understood the preceding statements above and have been given an opportunity to ask questions about them.

**Client Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Client Information Form**

*The following information will be kept strictly confidential.*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, & Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can I leave a message for you at the above phone numbers? Y or N \_\_\_\_\_\_\_\_

Initials

Emergency Contact Name/Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital/Relationship Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse(s)/Partner(s) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children(s) Name and Ages (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardianship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#: \_\_\_\_\_\_\_\_\_\_

Current Medications (Include prescribed dosages): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medical Conditions (diabetes, hypertension, head traumas, cardiac problems, asthma, breathing problems, cancer, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently pregnant? Y or N If yes, how many weeks? \_\_\_\_\_\_\_\_\_\_\_\_

Presenting Problem (What is bringing you here today? Please include onset, duration, intensity, and precipitating event.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any concerns you have (including: anxiety, depression, sleep, anger, losses/grief, loneliness, work, eating/food, communication, energy, mania, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to see changed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you think could prevent or block you from the change? \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle any of the following that pertain to you:

Alcohol Use

Anger

Anxiety/stress

Attention/ADHD

Career/Work

Communication

Concentration

Depression

Drug Use

Eating/Food

Energy

Family/Friends

Fears

Finances

Health Problems

HIV/AIDS

Legal Matters

Loneliness

Loss/Grief

Mania

Marriage

Overly Emotional

Pain

Panic Attacks

Paranoia

Personal Growth

Physical Abuse

School Problems

Self-Harm/Cutting

Separation/Divorce

Sexual Abuse

Sexual Concerns

Sexuality

Sleep Problems

Spiritual Issues

Suicidal Thoughts

Are you at risk of hurting yourself or someone else? \_\_\_\_\_\_\_

When did you last see a doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Explain \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous counseling or psychotherapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates Where

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had any past psychiatric hospitalizations (describe and list dates)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did you find past treatment helpful? Yes / No

What was helpful/not helpful? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you taken any psychiatric medications in the past? Yes / No

List:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you willing to consider taking medication for your current problems? Yes / No

Are you currently on leave from work or seeking disability? Yes / No

**Substance Abuse History**

Have you ever been treated for SA? (food, gambling, alcohol, drugs, sex): Yes / No

Are you currently attending any support groups? Yes / No

In the past 30 days what substances have you used?



Tobacco

Alcohol

Tranquilizers

Sleeping Pills

Pain Killers

PCP

Marijuana

Have you experienced any withdrawal symptoms?

Circle all that apply: headaches nausea vomiting tremors seeing things hearing things

Have you ever had a DUI: Yes / No

**Legal Issues**

Are you currently involved in any legal issues? Yes / No

Are you on parole or probation? Yes / No

Do you have any DFACS involvement? Yes / No

**Family and Relationships**

Please list anyone who lives with you, their age, and their relationship to you:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone in your immediate family have substance abuse, behavioral, or psychiatric problems?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your family supportive of you seeking treatment? Yes / No

Do you/have you suffered domestic violence? Yes / No

Do you have a history with sexual, physical, or emotional abuse? Yes / No

If so, which: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any sexual orientation or gender issues or concerns? Yes / No

Do you have any spiritual or religious affiliations? Yes / No

Describe your spiritual/religious affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your hobbies?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your support system:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

**Client Information Form**

*The following information will be kept strictly confidential.*

I freely give my permission for the therapy to be received. I understand that payment is due at the time of service unless prior arrangement has been made. I understand that if I do not cancel an appointment at least 24 hours in advance, I will be responsible for payment. Please Initial: \_\_\_\_\_\_\_\_\_

Client referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission for Tara Arnold, PhD, LCSW to send a written acknowledgement of the referral. Please Initial: \_\_\_\_\_\_\_\_\_

The client’s signature below indicates they have completed this form to the best of their ability and provided accurate information.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Therapy Partner**

**Electronic Payment Authorization**

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Visa, Mastercard, and Discover. This information will be securely stored in your clinical file and may be updated upon request at any time. Please be aware transactions will appear as Therapy Partner on your bank or credit card statement.

**Contact Information:**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, & Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Type:**

Credit/Debit Card Type (Check One): Visa\_\_\_\_\_\_ Mastercard\_\_\_\_\_\_ Discover\_\_\_\_\_\_

Credit/Debit Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date: \_\_\_\_\_ CVV: \_\_\_\_\_\_

**Account Holder Information:**

If name and address associated with credit card or bank account you wish to use are the same as above, please check here: \_\_\_\_\_\_\_\_

If not the same as above, please complete:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Client/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND 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 applicable federal and state law to maintain the privacy of your health information. I am also required to give you this notice of privacy practices, legal obligations, and your rights concerning your health information (Protected Health Information or PHI). I must follow the privacy practices that are described in this Notice of Privacy:

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

I may *use* or *disclose* your *protected health information* (*PHI or Clinical Record*), for *treatment, payment, and health care operations* purposes ***WITH YOUR CONSENT***. To help clarify these terms, here are some definitions:

1. “*PHI*” refers to information in your health record that could identify you.
2. “*Treatment, Payment and Health Care Operations*”

– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another counselor or therapist.

– *Payment* is when you obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer so that you may 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 my 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.

1. “*Use*” applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
2. “*Disclosure*” applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

**II. Uses and Disclosures Requiring Authorization**

I 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 I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain authorization before releasing your Psychotherapy Notes. “PSYCHOTHERAPY NOTES” are notes I have made about our conversation during a private, group, joint, or family counseling session, WHICH I HAVE KEPT SEPARATE FROM THE REST OF YOUR MEDICAL RECORD. THESE NOTES ARE GIVEN A GREATER DEGREE OF PROTECTION THAN PHI AND ARE NOT IN THE CLINICAL RECORD WHICH HIPAA REGULATES.

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

**III. Uses and Disclosures with Neither Consent nor Authorization: Also described in the Therapist-Patient Agreement:**

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

1. ***C****hild Abuse* *and Endangerment* – If I have reasonable cause to believe that a child has been abused or has witnessed acts of violence, I must report that belief to the appropriate authority.
2. *Adult and Domestic Abuse* – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
3. *Health Oversight* *Activities* – If I am the subject of an inquiry by the Georgia Board of Professional Counselors, Marriage and Family Therapists and Social Workers, I may be required to disclose protected health information regarding you in proceedings before the Board.
4. *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a 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.
5. *Serious Threat to Health or Safety* – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
6. *Worker’s Compensation* – I may disclose protected health information 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 illness without regard to fault.

**IV. Patient’s Rights and Psychotherapist’s Duties**

Patient’s Rights: (with respect to PHI/Clinical Record):

1. *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information (PHI). However, I am not required to agree to a restriction you request.
2. *Right to Receive* *Confidential Communications by Alternative Means and at Alternative Locations* –You have the right to request and receive confidential communications of protected health information (PHI) by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
3. *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
4. *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
5. *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
6. *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist’s Duties:

1. I am required by law to maintain the privacy of PHI/Clinical Record and to provide you with a notice of my legal duties and privacy practices with respect to PHI/Clinical Record.
2. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
3. If I revise my policies and procedures, I will mail you a notice or provide it during your next session.

**V. Questions and Complaints**

If you have questions about this notice, disagree with a decision I make about access to your PHI/Clinical Record, or have other concerns about your privacy rights, you may contact me. If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to me. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

**VI. Effective Date, Restrictions, and Changes to Privacy Policy**

I will limit the uses or disclosures that I will make as follows: These disclosure regulations apply only to PHI/Clinical Record, not Psychotherapy Notes, which have a higher level of protection.

**Acknowledgement of Receipt of**

**Notice of Privacy Practices**

By my signature below I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I received a copy of the Notice of Privacy Practice for Tara Arnold, PhD’s psychotherapy practice.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_

If this acknowledgement is signed by a personal representative on behalf of the client, please complete the following:

Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office use only: If unable to obtain written acknowledgement of receipt of our Notice of Privacy Practices, it was due to (please check appropriate answer):

\_\_\_\_\_\_ Individual refused to sign

\_\_\_\_\_\_ Communication barriers prohibited obtaining acknowledgement

\_\_\_\_\_\_ Emergency situation prevented us from obtaining the acknowledgement

\_\_\_\_\_\_ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully, and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today’s date as indicated below.

I, **\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (client), hereby authorize Dr. Tara Arnold, PhD, and the following party or parties to discuss my mental health treatment information and records obtained during psychotherapy treatment, including, but not limited to, therapist’s diagnosis:

(1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

\_\_\_\_ The parties stated above may discuss my medical and/or mental health information

without limitations.

\_\_\_\_ I would prefer to limit the information shared between the parties stated above. The

limitations I would like to make are as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additionally, the above-named parties, therapist & person(s) or entity (entities) designated under (1) or (2), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above-named therapist at 6 Lenox Pointe NE to be effective.

Client’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Parent’s/Legal Guardian’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Feel free to make notes of any questions or comments you’d like to remember to talk to Dr. Arnold about in your session:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_