**InMind, LLC**

**Counseling and Wellness**

*\*\*This form is completely confidential.\*\**

**Child Client Information**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Gender: □ Male □ Female

Parent/Legal Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Custodial Parent if Applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable, does anyone else share custody of child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Primary Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we leave a message? \_\_\_\_\_\_

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

Person to Notify in Case of Emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

May I have your permission to thank this person for the referral? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about InMind Counseling and Wellness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information**

Has your child ever received counseling before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain any significant medical problems or illnesses your child is currently dealing with. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any significant medical problems or illnesses in your child’s past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child currently under the care of a psychiatrist or other medical doctor for psychological/emotional issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, who is your child’s treating doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your child’s current medications. If you need more room, you may write on the back of the page.

Medication Dosage Purpose of Med Prescribing MD

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Has your child ever been diagnosed with a mental illness? \_\_\_\_\_\_ If so, please list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child expressed thoughts or plans of suicide or harming his/herself? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child expressed thoughts or plans of suicide or harming his/herself in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child expressed thoughts or plans of harming someone else? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child expressed thoughts or plans of harming someone else in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had a psychiatric hospitalization? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, when and where was his/her last hospitalization? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please briefly describe the reason for seeking counseling at this time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Legal Guardian Signature**: \_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**InMind, LLC**

**Counseling and Wellness**

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**INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT**

Thank you for choosing InMind Counseling and Wellness. We are pleased to assist you in working toward your therapeutic goals and to help you improve your well-being. We strive to create a safe, non-judgmental space in which you can grow and explore what is causing you emotional pain. The purpose of this document is to inform you about what to expect from the therapeutic process and your therapist, to inform you of policies regarding confidentiality and emergencies, and information about our general office policies.

**Theoretical Views & Client Participation**

Our therapists practice from a person-centered theoretical perspective, while incorporating various therapeutic techniques as needed including but not limited to Cognitive Behavioral Therapy, Mindfulness Therapy, Dialectical Behavioral Therapy, and Play Therapy for children. We meet you where you are in your journey and help you become more self-aware and gain insight into the areas of your life in which you need to heal in order to obtain a more content state of mind. In order for therapy to be effective, it is important that you take an active role in the process. This means going beyond your therapy sessions and practicing what you and your therapist discuss between sessions. This also means refraining from using any mind altering substances at least 8 hours prior to your session. Due to the subjective nature of the therapeutic process, there is no way to guarantee how long it will take to achieve your goals or to feel a change. Some clients reach their goals within a few sessions, while others need months or even years to meet their goals. Please understand that change takes time. However, we don’t believe in fostering dependency on therapy. Our goal is to empower you to use the tools, skills, and perspectives you learn in therapy to have the kind of life you desire. If at any time you or your therapist believe that your therapy isn’t helping you reach your goals and that you need other resources, your therapist will assist you in finding those resources.

**Confidentiality & Records**

InMind Counseling and Wellness is in compliance with the legal and professional standards for the maintenance and storage of psychotherapy treatment records. Your communications with your therapist will become part of a clinical record of treatment, which is referred to as Protected Health Information (PHI). Your PHI will be kept confidential and secure and will be stored electronically in Therabill.com, a medical electronic filing system designed for therapists, which is password protected and only accessible by your therapist. In addition, your therapist will always keep what you say in session completely confidential with the following exceptions:

• If you sign a Release of Information form requesting that your therapist share your information with someone else, i.e. your doctor.

• If your therapist determines that you are a danger to yourself. This might include contacting a family member, hospital emergency room, or psychiatric hospital.

• If your therapist determines that you are a danger to others. The American Counseling Association’s Code of Ethics states that therapists have a Duty to Warn. This might include warning that person directly, contacting the police, or a family member.

• Court order or subpoena. In this case, your therapist’s license provides him or her with the ability to uphold what is legally termed “privileged communication.” This refers to your right as a client to have a confidential relationship with a counselor. The State of Georgia has a very good track record in respecting these legal rights. If required by a Judge to turn over your records, this order can be appealed. However, we cannot guarantee the appeal with be sustained.

• If your therapist has concerns about the abuse or neglect of a child, elderly, or disabled person, they will notify the Department of Family and Children’s Services (DFCS) to report this concern. This is also a requirement of the American Counseling Association’s Code of Ethics.

Please note that in couple’s counseling your therapist will not keep secrets between partners. Effectiveness of therapy is threatened when secrets are kept between partners; therefore, information revealed in any context may be discussed with either partner.

If at any time, you wish to receive information from your official client record, please make this request to your therapist. Once copied, your therapist will review your record with you.

**In Case of an Emergency**

InMind Counseling and Wellness is considered an outpatient group practice, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry pagers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss more appropriate resources for you or will facilitate transfer to a more appropriate facility with 24 hour availability. Generally, our therapists return phone calls within 24-48 hours unless other parameters have been previously discussed. It is not appropriate to notify you therapist via email in case of an emergency. In case of mental health emergency, do not wait for us to call you back. Please contact one of the following:

• Willowbrook at Tanner 770-456-3266; 24 hour help line 770-836-9551

• Ridgeview Institute at 770-434-4567

• The GA Crisis and Access Line 1-800-715-4225

• Call 911 or go to your nearest emergency room.

**Structure and Cost of Sessions**

Your therapist agrees to provide psychotherapy for the fee of $120 per 50-55 minute Intake Session and $95 per 45-55 minute ongoing sessions unless otherwise negotiated by you or your insurance carrier. If you are planning to use insurance, you will be charged according to your insurance plan. This will be your copay, coinsurance, or deductible payment. Doing psychotherapy by telephone is not ideal and is not HIPAA compliant due to new technologies available that can allow eavesdropping. Needing to talk to your therapist over the phone between sessions may indicate that you need extra support in the form of additional sessions or additional resources. (Please see below regarding emailing your therapist.) Sessions are 45-55 minutes duration. If you are 15+ minutes late, your appointment will be rescheduled and you will be charged a late cancellation fee. We are unable to bill insurance if you are 15+ minutes late. If your appointment is able to be rescheduled within 5 days, and if you keep this appointment, you will not be charged.

With regard to insurance: Insurance companies have many rules and requirements specific to your individual plan. It is your responsibility to know your plan and to find out your insurance company’s policies. As a courtesy to you, we will call and determine your eligibility and benefits prior to your initial appointment. If new information is given by your insurance company at a later date, i.e. plan changes, etc., you are responsible for any changes in the cost of your sessions. If at any time you change insurance plans, please notify us as soon as possible to avoid unplanned charges.

\*Please read the “Fees” page of this packet for information on fees other than cost of sessions.

**Professional Relationship**

Psychotherapy is a professional service provided to you. Because of the nature of therapy, the relationship with your therapist is different than other relationships you have with professional providers. It may differ in how long it lasts, the objectives, or the topics discussed. It must be limited to only the relationship of therapist and client. Having an outside relationship with your therapist is considered a dual relationship according to the American Counseling Association’s Code of Ethics. Having a dual relationship could prove harmful to you in the long run and is considered unethical in the mental health profession. However, it is not uncommon for clients to see therapists in the community from time to time. In many instances, this cannot be avoided. You should know that therapists are required to keep the identity of their clients confidential. To keep your confidentiality protected, your therapist will not address you in public unless you speak to him or her first. Your therapist must also decline any invitation to attend gatherings with your family or friends. Upon completion of your therapy, your therapist will not be able to engage in a friendship with you. Please understand that these guidelines are for your long term protection.

**Electronic Communication, Use of Technology, and Social Media**

InMind Counseling and Wellness is dedicated to taking the necessary precautions to protect your confidentiality. Emails, texts, and other forms of electronic communication can be helpful tools for communicating between sessions regarding non-clinical issues such as scheduling or other logistics. However, these forms of communication are not always completely secure methods of communication; therefore, cannot guarantee client confidentiality. Although our emails are password protected, they are technically viewable by the email/Internet Service Provider. It is also possible for email accounts to be hacked. Please keep this in mind when sending your therapist an email.

Electronic communication may be used to initiate and obtain information about therapeutic services but is not an appropriate medium for discussing clinical/therapeutic issues or terminating services. Please only discuss these details in your sessions. Also, in an effort to maintain a professional/therapeutic relationship, our therapists do not accept requests from current or former clients on social networking sites.

By signing below, you indicate that you have read and understand the Information,

Authorization, and Consent to Treatment and understand the parameters of confidentiality as they apply to you and consent to abide by those policies and to engage in treatment with our practice.

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date

**InMind, LLC**

**Counseling and Wellness**

**Fees Policy**

* Session payment is due at time of service, prior to session.
* A $65 fee will be charged for all no-show appointments.
* A $65 fee may be charged if we aren’t notified of appointment cancellations 24 hours before your appointment, depending on circumstances and at the discretion of your therapist. We are only paid by clients and insurance companies. We are unable to bill your insurance company for late cancellation and no-show appointments. We have waitlists, and notification the day before gives us time to fill your appointment.
* You will be rescheduled if you are more than 15 minutes late for your appointment and you will be charged a late cancellation fee. We are unable to bill insurance if you are more than 15 minutes late.
* There will be a minimum charge of $400 for first 2 hours and $150 for each additional hour if your therapist is asked to attend court. The initial $400 will be due up front. Checks are not accepted for this service.
* There will be a $25 on all returned checks.

\*Please Note: **We do not allow running balances. Payment is due at time of service**. If you do not have payment at time of service, we’ll be happy to reschedule you.

\*We accept cash, check, and all major credit/debit cards.

I have read and understand the Fee Policy for InMind Counseling and Wellness.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**InMind, LLC**

**Counseling and Wellness**

***Acknowledgement of Receipt of Notice of Privacy Practices***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of InMind, LLC’s Notice of Privacy Practices and understand that this office operates in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**