Family Counseling Service, Inc.

Appt. Date_____

Appt. Time_____

Location_____

Service Record

For Office Use Only

Client Number _____ Category_____Intake Date_____ Office Location_____ Assigned Counselor_____

Intake Coordinator _____Record Name_____ Base/Incent._____

Client Fee Responsibility_____ S. F. S. Credits_____ Third Party Payor Name_____ Amount

Please complete the next section for the person identified as the primary person receiving services. Example: for you-your name, for couples or families-the name of either adult, for child-the name of child.

Name _____ Age ____ DOB _____ Sex ____ Race ____ SS#_____

Address _____ City _____ State _____ Zip _____County_____

Phone (H)_____ (W)_____ (C) _____

Marital Status _____ Spouse/Partner Name_____

Emergency Contact Name:_____ Phone_____

_____

****Notice to Couples:** The record will be established in the name of the caller. Therefore any records release will require this person's signature.

Problem Statement and Scheduling needs:

Briefly describe why you are seeking help_____

What, if anything, led to your contacting us at this time (i.e. recent incident, court or employer involvement, etc.)

_____

Have you had any past treatment for these same concerns? If so, where?_____

What days/times are best for you to schedule appointments?_____

WORK / INCOME INFORMATION

(Identify all sources of Household Income) This information is necessary for anyone requesting a fee at or below our minimum fee (see fee agreement)

Source of Income_____	**Amt:** _____**Yearly**	**Wage Earner**_____

INSURANCE INFORMATION

Employer Name:_____Insured Name if different than client_____

Relationship to client___ _____Member ID #_____Insured's SSN _____

Insured's D.O.B._____Plan Name_____Group #_____

Insurance Company_____

Billing address_____

Phone# to verify coverage (on back of card) _____ _____Spoke to: _____

Policy covers: MD Ph.D. L.C.S.W. L.M.F.T. L.P.C. Panel Members Only

Policy Effective_____Deductable **Amt**_____**Amt Met**_____**Amt Left**_____

Number of Visits (Annually)_____**or (July to July**)_____Reimbursement Rate_____% or_____

EAP (See paperwork to complete) PPO HMO INDEMITY

Authorization Required (Call or send TX Plan after initial authorizations are used) No Authorization Required

Authorization:Units_____Procedure_____From_____To_____#_____

Authorization:Units_____Procedure_____From_____To_____#_____

****Person Authorized** _____**Confirmed by**_____**On**_____

FAMILY COUNSELING SERVICE, INC.

FEE AGREEMENT

Funding support from the United Way allows Family Counseling Services (FCS) to provide counseling on an ability to pay basis including a lowered fee for those with no income or others who cannot afford the Agency's minimum fees.* Ability to pay is defined as gross household income and insurance coverage as indicated below:

		Therapist	Psychologist	Other
1.	Standard charge per session	$ 105.00	$ 125.00	$ 105.00
2.	Minus amount to be paid by insurance	$ _____	$_____	$_____
3.	Remaining balance	$ _____	$_____	$_____
4.	**Client fee obligation** (co-payment) to be paid each visit (at $1.25 per $1,000 annual income with $40.00 minimum)	$ _____	$_____	$_____

**Benefits quoted by your insurance carrier, including copayment are not a guarantee of payment until a claim has been filed. Therefore, please be aware that your client obligation is subject to change.

5.	Amount of United Way support to be applied each visit due to ability to pay agreement (The difference, if any, between #3 and #4)	$ _____	$_____	$_____

* Due to a limited number of staff openings for those requesting waiver of the standard fee, requests will be handled on a "first come-first served" basis. Anyone requesting a fee below the standard charge ($105) must complete the work/income information on page one and provide proof of income.

Total amount of household income $_____ Weekly Monthly Annually

Your medical insurance may be used to pay a portion of the Agency's standard charges. We will file for you provided you sign the Assignment of Benefits Statement below. Clients who have insurance coverage may elect not to use it; however, they will be responsible for payment of the amount which would have been collected through insurance **in addition to** their co-payment (item #4 on above fee agreement.) If your deductible has not been met, you are responsible for the entire amount of the standard charge until the deductible has been met, payment plans are available. **Your insurance can not be billed for missed or late cancelled appointments.**

I understand that unless I give **twenty-four(24) hour notice of cancellation** I am responsible for payment.
X_____ Please initial. ***ALSO READ AND SIGN ATTACHED PROCEDURE REGARDING MISSED APPOINTMENTS***.

Rights To Privacy Notificiation

My initials here indicate I have been advised of the Notice of Privacy Practice X_____.

ASSIGNMENT OF MEDICAL BENEFITS

I hereby assign all medical benefits which I am entitled to Family Counseling Service, Inc. A photocopy of this assignment is to be considered as valid as an original. I further authorize said assignee to release all information necessary to secure medical payments for services rendered.

_____ _____ _____
Signature Date Birth date Social Security Number

_____ _____ _____
Signature Date Birth date Social Security Number

_____ _____
Witness Date

WELCOME TO FAMILY COUNSELING SERVICE

Thank you for choosing Family Counseling Service Inc. We provide the following information to help you understand how we work and to answer questions commonly asked about counseling or therapy.

HOURS OF OPERATION/SCHEDULING-Our business office is open Monday through Thursday 9:00 a.m. to 5:00 p.m. and Fridays from 9:00am-4:00pm. Therapy sessions are "as scheduled" between you and your therapist. Business office staff keep all therapy schedules. Canceled or rescheduled appointments can be done without talking directly with the therapist. However, we require **24-hour notice** to avoid charges for the session**.*** ***See attached procedure regarding missed appointments.***

STAFF QUALIFICATIONS- A. Clinical Staff -Our staff is professionally trained with advanced degrees in social work, counseling, marriage and family therapy, and psychology. All are licensed to provide these services. State licensure requires a masters or doctorate degree and one to four years post graduate experience supervised by other licensed professionals.

B. Associate Staff Associate staff have the same training and education as clinical staff and are awaiting licensure pending completion of their post graduate experience and supervision requirements.

C. Interns As a field instruction site for the University of Georgia, we also use staff that are completing the internship portion of their advanced college degree. Similar to medical doctors, professional counselors, marriage/family therapist, and social workers must complete supervised internships as part of their professional training. Our partnership with the University of Georgia ensures that our clients have access to the latest information and developments in our profession.

WHAT TO EXPECT FROM THERAPY-The best foundation for therapy is the relationship you develop with the therapist. Therefore, it may take a few visits for you to get comfortable talking about personal matters and for your therapist to develop a plan to deal most effectively with your concerns or needs. Generally by your fourth visit you and your therapist should have a common understanding of how therapy may be of continued benefit to you. If you need additional referrals, your therapist will assist you in locating other resources.

TEAM CONSULTATIONS -As part of a group or agency practice your therapist often works as part of a team of professionals. This team consults with one another to ensure the best treatment is being provided to you and / or your family. At times you may be asked to video tape a session for later review with your team. All taping is done with your permission.

PROBLEMS/COMPLAINTS-If at anytime you are concerned about either your relationship with your therapist or your progress, please do not hesitate to discuss these issues with your therapist. You may also ask to speak with the Agency Director if you have concerns that cannot be resolved with your therapist.

CONFIDENTIALITY-Your therapist will not share information with any person outside our agency without your written permission, except as required by law or in a situation deemed potentially life-threatening.

EMERGENCIES- Since we are not a 24 hour facility, emergency services are limited to crisis assessment of life threatening situations and referral to an emergency receiving facility. Your therapist will discuss these options with you when or if it becomes necessary during treatment.

CONSENT TO SERVICES-I hereby authorize the professional staff of Family Counseling Service (FCS) to provide therapy, counseling and other treatment as deemed necessary for me. I understand that information provided FCS staff will not be shared with anyone without my written consent except in situations mandated by state or federal law, i.e. threat to self or others including child abuse or neglect.

I (we) have read the above statement of procedure at Family Counseling Service and, understand its purpose and potential benefit to me (us) hereby consent to services. I (we) understand that this consent may be withdrawn at any time.

X_____ _____

Signature of client(s) or Guardian *Date*

Over →

Current Concerns

Please provide the following information so we may better address your concerns.
A) First, how have your concerns affected your:

	Does not apply	Not at All				Very Much
Marriage /Partner	**N/A**	**1**	**2**	**3**	**4**	**5**
Family	**N/A**	**1**	**2**	**3**	**4**	**5**
Eating Habits	**N/A**	**1**	**2**	**3**	**4**	**5**
Sleeping Habits	**N/A**	1	**2**	**3**	**4**	**5**
School or Work Performance	**N/A**	**1**	**2**	**3**	**4**	**5**
Ability to Concentrate	**N/A**	**1**	**2**	**3**	**4**	**5**
Health	**N/A**	**1**	**2**	**3**	**4**	**5**
Motivation/ Energy	**N/A**	**1**	**2**	**3**	**4**	**5**
Ability to Parent Children	**N/A**	**1**	**2**	**3**	**4**	**5**
Ability to Manage Anger	**N/A**	**1**	**2**	**3**	**4**	**5**
Ability to Trust Others	**N/A**	**1**	**2**	**3**	**4**	**5**
Ability to Establish Relationships	**N/A**	**1**	**2**	**3**	**4**	**5**

B) MEDICAL HISTORY

Yes No High Blood Pressure
Yes No Diabetes
Yes No Lung Problems
Yes No Heart Problems
Yes No Kidney Problems
Yes No Liver Problems
Yes No Miscarriages
Yes No Learning Problems
Yes No Nerve Problems
Yes No Menopausal Symptoms
Yes No Mental Illness/ Schizophrenia
Yes No Depression
Yes No Drinking Problems
Yes No Drug Problems
Yes No Cancer
Yes No Seizures
Yes No Other_____

C) DEPRESSION

How often in the last two weeks has this statement been true for you? (If completed for someone other than yourself, put name here and answer based on statements made to you:

1. Felt depressed ..... 0 1-2 3-4 5-7 Days
2. Felt tired ..... 0 1-2 3-4 5-7 Days
3. Avoided people .....0 1-2 3-4 5-7 Days
4. Lost pleasure in things usually cared about or enjoyed? Yes No
5. Felt depressed or sad much of the time in the past year? Yes No
6. Two or more years in life when depressed or sad most days, even if okay sometimes? Yes No
7. Considered suicide? Yes No
8. Attempted suicide? Yes No

D) DRINKING/DRUG ABUSE HISTORY

1. Has anyone (significant to you or yourself) attempted to stop drinking/using other drugs?
A) Yes_____ B) No

2. Has anyone (significant to you or yourself) expressed concern about the drinking or use of non-prescription drugs by someone else in the home?
A) Yes_____ B) No

3. Has an employer been concerned about someone's (significant to you or yourself) alcohol/drug use?
A) Yes_____ B) No

4. Has anyone had a DUI?_____

E) Prescriptions Used /Prescribed by Whom:

_____
_____
_____
_____

F) SAFETY

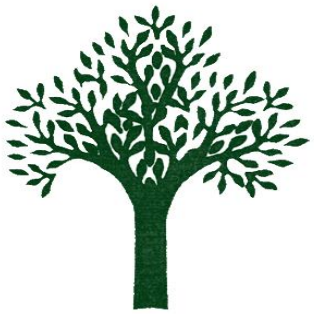
Current Concerns

1. In the past year, have you or others ever felt threatened? Yes No
2. In the past year, have you or others been pushed, hit, or threatened? Yes No
3. In the past year has there been a pattern of verbal abuse or intimidation? Yes No
4. In the past year, have you or others been sexually abused? Yes No
5. In the past year have you threaten pushed, hit, or verbally, physically or sexually abused others? Yes No

G) OTHER CONCERNS

What other concerns do you wish to discuss?

_____
_____



MISSED OR CANCELLED SESSIONS

As indicated on the Consent to Services form you signed at your initial visit, we ask for a 24 hour notice to cancel appointments. We understand that there may be an isolated unforeseen emergency where it is difficult or impossible to give adequate notice. Barring such rare circumstances, the following guidelines apply to missed sessions without adequate notice.

PLEASE READ THE FOLLOWING CAREFULLY

A. If you are using insurance for therapy, there will be a $50 charge for a missed session. Please be aware that ***your insurance company cannot be billed if you are not present,*** therefore you will be responsible for the $50 charge regardless of your co-pay.

B. If you are not using insurance (paying out of pocket), and your assessed fee is less than $50 per session, you are responsible for paying your assessed fee.

C. If you are using your Employee Assistance Program (EAP), there is no charge for a missed session; however, you will have one less session available to you.

D. If missed appointments become a concern, your counselor will discuss this with you. Should this continue to be a problem, please be aware that FCS reserves the right to require pre-payment for sessions or even discontinue sessions.

Feel free to call FCS (706-549-7755) should you need to verify your appointment day or time.
Your signature below indicates your understanding and agreement to adhere to the above policy. If you have questions about this policy please discuss them with your therapist.

_____
Print Client/Legal Guardian Name

_____ _____
Signature Date

Family Counseling Service of Athens. Inc.
1435 Oglethorpe Avenue Athens. Georgia 30606
(706) 549-7755

NOTICE TO OUR CLIENTS REGARDING PRIVACY PRACTICES

As you are probably aware, federal law requires that you be notified of your rights regarding protection of information you share with us during treatment. The information on this form summarizes those rights as defined in federal law.

Signing this form only indicates you have been made aware of these rights. It does not authorize us to release any information regarding your services here. It is our policy to only release information after you have signed **our** consent form. The only exception to this is situations that are mandated by state or federal law; i.e. threat to self or others including child abuse or neglect as stated in our consent to services form which is also included for your signature.

In other words our protection policy is stricter than the federal guidelines. If you have any questions please discuss the1n with your therapist.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your therapist, clinical nurse specialist, psychiatrist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a therapist, clinical nurse specialist, or psychiatrist to whom you have been referred to ensure that these individuals or organizations have the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in the course of normal business operations. These activities include, but are not limited to, case review, quality assessment activities, supervision of health care workers in training, licensing, and conducting or arranging for other business office activities. For example, we may disclose your protected health information to student inte1ns that see clients at our office. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Sharing Your Information: There are situations when we are permitted, and in some instances, required to disclose information without your authorization. These situations are; when a state or federal law mandates that certain health information be reported for a specific purpose: for public health purposes, such as contagious disease reporting, investigation or surveillance; for notices to and from the Federal Food and Drug Administration regarding drugs or medical devices; to protect victims of abuse, neglect, or domestic violence; for health oversight activities, if any, required of us such as co1nplaint investigations, licensing, audits, and inspections; for lawsuits, legal proceedings, and when otherwise required by law; when requested by law enforcement as required by law or court order; to report criminal activity; to report to coroners, medical examiners, and funeral directors; for inmates for organ and tissue donations; for research approved by our review process under strict federal guidelines; to reduce or prevent a serious threat to public health and safety; for workers' compensation or other sin1ilm·progra1ns if you are injured at work; for specialized government functions such as military activity, intelligence, and national security; for incidental disclosures that are an unavoidable by-product of providing treatment, obtaining pay1nent or office operations. For example, front office staff responsible for records maintenance and billing.

Finally, under the law, we must make disclosures to you and, if required, by the Secretary of the Depart111ent of Health and Human Services to investigate or determine our compliance with the requirements of Private Practices Law.
Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object unless required by law.

You May revoke this authorization, at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial. Under federal law, however, you may not inspect or copy the information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; protected health information that is subject to law that prohibits access to protected health information, and in some instances psychotherapy notes taken by your therapist.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

However, your therapist, clinical nurse specialist, or psychiatrist is not required to agree to a restriction that you may request if the therapist, clinical nurse specialist or psychiatrist believes it is in your best interest to permit use and disclosure of your protected health information. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your therapist, clinical nurse specialist or psychiatrist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against yon for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Grace Edmonds, in person or by phone at 706-549-7755.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature_____Date_____