Welcome to Cornerstone Counseling Services, LLC
Individual Therapy Adult Client Form

Welcome and thank you for choosing Cornerstone Counseling Services, LLC. This document is designed to answer some frequently asked questions about myself, the counseling process, my professional relationship, confidentially and your financial obligation. As you read this document, feel free to mark any places which are not clear to you or with any question you would like to further discuss.

The ultimate goal of the counseling process is that you will develop the self-awareness and coping skills necessary to face life's challenges independently. Success cannot be guaranteed with counseling; however I am committed to utilizing a number of highly researched approaches to therapy. If you do not feel an approach is working, please discuss with me your concerns. We will work together to find the best solution for you.

The nature of the counseling process is very personal. Therefore, we maintain a professional relationship consistent with accepted ethical standards. You are in complete control and may end our professional relationship at any time. I do not take on a client whom, in my professional opinion, I cannot help using the knowledge and techniques I have available. If I do not feel that I can be of help, I will refer you to others or agencies which would be better able to serve your needs. If necessary, I will make these referrals at our initial conversation on the telephone or in our initial meetings. In some cases it takes multiple meetings to assess one's needs or we may come to a point where I feel that I can no longer meet your needs. If that occurs, we will talk about the issues and I will direct you to the person or services which will be better able to serve your needs.

What to expect at the first appointment:

Your initial meeting will be 60 minutes in length. There will be an initial "intake session" completed by asking a variety of question regarding the presented issue(s) and your related background. At the end of the session, I will provide recommendations. It will be helpful at that time for you and your counselor to discuss and decide on the options and recommendations you want to pursue. Subsequent counseling sessions will be 60 minutes in duration. Extended sessions can be arranged as needed by prior agreement with your counselor.

Cornerstone Counseling Services, LLC
Individual Adult Client Information

The purpose of the following questionnaire is to help your counselor understand some important things about you in order to help you most effectively. Please complete all pages.

Name_____ Date_____
(Last) (First) (Middle)

Address_____

City_____ Zip Code _____ E-mail_____ Phone

(H) _____ Permission to call ___Y ___N Leave Message ___ Y ___N

Phone (W) _____ Permission to call ___Y ___N Leave Message ___ Y ___N

Cell phone _____ Permission to call ___Y ___N Leave Message ___ Y ___N

Emergency Contact_____
(Name) (Relation) (Phone)

Birth Date_____ Age_____ Gender _____M _____F

Marital Status:

I am: Single____ Married ____ Divorced____ Engaged____ Separated____ Widowed____ Partnership____

Name of Spouse/Significant other: _____ Age _____

If in a relation length of time together: _____ years _____ months

Name of Spouse/Significant other_____

Spouse's/Significant Other's Age_____

Is your Spouse/Significant other currently living with you?_____

Previous Marriages #s and length of each_____

Please list the names and ages of your children:

Names:	Ages:	Indicate where they live:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Occupation:_____Place of Employment:_____ Years:_____

Any major career changes?_____ If yes, from:_____ to:_____

Education & Degree: (if applicable)_____

Name of church you attend: (if applicable)_____

How did you hear about Cornerstone Counseling Services? _____

If referral, who referred you to Cornerstone Counseling Services?_____

Family History

Describe your family's relationship with one another growing up? (ex: how did your parents get along, how did you and your siblings get along?). _____

_____

_____

Discuss your current relationship with your parents: _____

_____

Please list your brothers, sisters, and yourself in birth order starting with the oldest. Give their ages.

Be sure to include yourself by indicating "me".

Names:	Ages:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Does someone in your family struggle with substance abuse? _____

_____

Has someone in your family ever received counseling or psychiatric diagnosis? _____

_____

Have you or a family member ever experienced domestic violence? _____

Client History

My health is: Excellent_____ Good_____ Average_____ Poor_____

Date of last medical exam? _____

Please list any medical or mental health diagnosis. _____

_____

Do you take medication?_____ Type or Name?_____

Have you ever received counseling before? Yes_____ No_____

If so, list counselor(s) and dates:_____

What was helpful? Yes_____ No _____ If not, why?_____

Have you had any major losses or traumatic experiences in your life?

_____

_____

What event or crisis led you to seek counseling at this time? _____

_____

_____

Describe how you hope counseling will help you:

_____

_____

_____

_____

_____

_____

Policies

Please initial where indicated, stating you have read and understand the information provided.

Confidentiality- A very important aspect of developing the openness, honesty, and trust between counselor and client is confidentiality. Whatever you share with your counselor will be kept in the strictest confidence and will not be disclosed to anyone without your express, written consent. At the same time, it is important for you to know that, under Georgia law; a few situations sometimes arise in which your counselor is both legally and ethically required to make disclosures that are necessary to ensure the safety of yourself or others. Those situations include: suspected child abuse, threat of physical violence to others, and/or suicidal intent. Your counselor will further discuss any aspect of confidentiality, which may concern you.

Initials _____

Court- Your counselor will not participate in divorce or child custody proceedings because the same professional should not perform evaluation and therapy. If subpoenaed by the court of law, I will first assert client-counselor privilege. However, if ordered by a judge to disclose information, my fees for appearing in court are an hourly rate of $200 and must be paid at the end of each day in attendance.

Initials _____

Emergencies- If you have an emergency (something that cannot wait for your next appointment), please call 678-954-5814. I will make every effort to return your call in the same day you make it, with the exception of weekends and holidays. If you feel that you cannot wait, please call 911 or go to the nearest Hospital Emergency Room for help. Please do not wait for your counselor to contact you to utilize those resources. If I am going to be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Initials _____

Insurance- Since each insurance company is different in the health benefits it provides, there can be no guarantee that the counseling services you receive will be covered. Although your counselor is a qualified and licensed professional, exact requirements for payment vary. You should be able to ascertain your plan's eligibility from your agent, your insurance company, or your employer. In the event that your insurance company requires correspondence with your counselor in order to reimburse you for services provided at Cornerstone Counseling Services, LLC, you will be asked to provide specific written consent for the counselor to communicate with your insurance company. Please let your counselor know if you intend to file a claim.
Are you planning to file a claim for reimbursement of services with your mental health insurance provider? ___ Y ___ N

Initials _____

Cancellation Policy- All cancellations should be made via email. Your counselor will confirm your cancelled appointment via email. For cancellations occurring at least 24 hours prior to your appointment time, no charges will be incurred. For cancellations occurring less than 24 hours prior to your appointment time, the full charge for your scheduled session will be applied. For appointments not kept (and not cancelled) the full amount will be charged.

Initials _____

Payment and Returned Check Fee- Payment in full is due when services are rendered unless other arrangements have been made in advance. Fees are charged for in office sessions and phone consultations. There is a $30 returned check fee in addition to the fee for service.

Initials _____

Please sign below, indicating that you have read, understood, and received a copy of this information. If you have any questions or concerns, please discuss before signing.

Print Full Name: _____

Signature: **Date**:

Policies

Keep This Copy for Your Records

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Insurance- Since each insurance company is different in the health benefits it provides, there can be no guarantee that the counseling services you receive will be covered. Although your counselor is a qualified and licensed professional, exact requirements for payment vary. You should be able to ascertain your plan's eligibility from your agent, your insurance company, or your employer. In the event that your insurance company requires correspondence with your counselor in order to reimburse you for services provided at Cornerstone Counseling Services, you will be asked to provide specific written consent for the counselor to communicate with your insurance company. Please let your counselor know if you intend to file a claim.

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Please sign below and keep the two subsequent pages of information for your records.

Georgia Notice Form:

By signing below, I am acknowledging that I have received a copy of the Georgia Notice Form concerning the policies and practices protecting my health information.

Print Full Name: _____

Signature: _____ Date_____

Georgia Notice Form
Notice of Licensed Professional Counselor Policies and Practices to Protect the Privacy of Your Health Information

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. Uses and Disclosures for Treatment, Payment, and Heath Care Operations
I may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment" 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 family physician or another psychologist.
- "Payment" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health care insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- "Health Care Operations" are activities that relate to the performance and operation of 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.
- "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "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 an 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. 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 that insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither consent nor Authorization
I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse - If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- Adult and Domestic Abuse - If I have reasonable cause to believe that a disabled adult or elder person has had 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.
- Health Oversight Activities - If I am the subject of an inquiry by the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Counselors Examiners, I may be required to

• 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.
• 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.
• Workers 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 Licensed Counselor's Duties

Patient's Rights:

• Right to Request Restrictions - you have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction that you request.
• Right to Receive Confidential Communications by Alternative Means and at Alternative Locations -- You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
• Right to Inspect and Copy -- You have the right to inspect and/or obtain a copy 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 the details of the request and denial process.
• Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
• 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.
• Right to a Paper Copy - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Licensed Counselor's Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
• 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.
• If I revise my policies and procedures, I will inform you of that change in a session or on the phone, and that information may be also provided to you in written form while you are in a session or through the mail.

V. Complaints:

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please inform me. You may also contact the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Counselors. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

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

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, I will promptly distribute the revised Notice, post it in the waiting area of my office, and make copies available to my patients.