THERAPY CENTER
Counseling & Consultation

1817 Green Circle
Valdosta, GA 31602
Phone: 229-244-9688
Fax: 229-244-5354

Please Print Information

Last Name_____First_____Middle_____

Mailing Address _____Street _____

City/State _____County_____Zip_____

Phone (home) _____ (work) _____ (other) _____

Contact Email: _____

SSN_____Birthdate_____Age_____Race_____ Sex ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female

☐ Transgender (as non-binary) ☐ Non-binary ☐ Two-Spirit ☐ Not sure ☐ Choose not to disclose

Patient Employer/School _____Occupation_____How long/grade _____

Address _____City/State _____ Zip_____

Marital Status: Single☐ Married☐ Divorced☐ Separated☐ Widow☐

Family Doctor_____Phone_____

Referred By_____Phone_____

Reason for Referral _____

Person Completing Form: _____Phone_____

☐ Self ☐ Biological Parent ☐ Adoptive Parent ☐ Foster Parent

☐ Kinship Placement ☐ Other _____

NOTIFY IN CASE OF EMERGENCY

Name_____Phone_____

Address_____City/State_____

Relationship_____

LEGAL GUARDIAN INFORMATION/PERSON RESPONSIBLE FOR BILL

Name_____ Home Phone_____

Address_____ City/State_____

Employer_____ Work Phone_____

SSN_____ DOB_____ Relationship_____

INSURANCE INFORMATION

	Primary	**Secondary**
Name of Insurance Comp	_____	_____
Policy Number	_____	_____
Group Name	_____	_____
Group Number	_____	_____
Name of Insured	_____	_____
Insured D.O.B	_____ _____	_____
SS# of Insured	_____	_____
Employer of Insured	_____	_____

PLEASE READ CAREFULLY

The patient is responsible for ALL fees, regardless of Insurance Coverage.

All charges are due at time of service unless other arrangements have been made in advance. I understand that I am responsible for any amount NOT covered by insurance. I hereby authorize payment directly to Therapy Center Counseling and Consultation all insurance benefits not to exceed the Center's regular charges. I hereby authorize Therapy Center Counseling and Consultation to release the information needed to any physician and/or third party responsible for payment of such services.

APPOINTMENTS- Schedule, change, and cancel appointments through the main office. If you find that you cannot keep your appointment, notify our office as soon as possible. A charge may be made for all appointments not canceled 24 hours in advance, and this charge will be the responsibility of the patient.

AUTHORIZATION FOR TREATMENT/ACKNOWLEDGEMENT OF PATIENT RIGHT

I, the undersigned, hereby request treatment by the staff of Therapy Center Counseling and Consultation. I understand that this office does not discriminate on the basis of race, creed, religion, age, sex, political affiliation, physical or mental handicap. I realize that such treatment will be conducted by a treatment team which may include therapists, social workers, psychologists, medical doctors and under appropriate supervision. In addition, I understand that I have rights as a patient and realize procedures exist to file any grievances that may arise during treatment. This authorization will continue in effect until revoked in writing.

Notice of Privacy Practices

This _____Day of _____20_____

_____ _____ _____

(Patient's signature or legal guardian) (Date) (Staff's signature)

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Notice of Privacy Practices

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.

Uses and Disclosures

Treatment: Our Staff members may disclose your health information to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, laboratory test results and treatment will be available in your medical record to all health professionals who may provide treatment or who may be consulted to treat you.

Upheal BAA: Therapy Center Counseling and Consultation uses external providers to enhance services including the Upheal platform. Upheal empowers counselors to concentrate on their services by offering automated notes and analytics for client conversations. As a part of this process, Upheal handles protected health information for counselors, adhering to HIPAA regulations as a Business Associate. Therapy Center Counseling and Consultation has signed a Business Associate Agreement (BAA) to protect data that is shared with Upheal. Under the BAA, Upheal adheres to regulations such as the HIPAA Security Rule and Privacy Rule. This ensures that electronic health information (ePHI) is safeguarded through appropriate administrative, physical, and technical measures, ensuring its confidentiality, integrity, and security. You can learn more about Upheal and its privacy practices at www.upheal.io/privacy.

Payment: Your health information may be used to seek payment from your insurance plan or from other sources such as credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the service provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Therapy Center Counseling and Consultation. For example, we may allow access to your medical information to students working with us; we may call you by name from the waiting room.

Law Enforcement: Your health information may be disclosed to Law Enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Wemay disclose your health information to public health agencies as required by law. For example, we are required to report certain communicable diseases to the State's Public Health Department.

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation or the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

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Individual Rights

You have certain rights under Federal Privacy Standards. These include:

- The right to request restrictions on the use and disclosure of your health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information. (Patient Access is limited with regard to psychotherapy notes.)
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy, policies, and practices. These changes may be required by changes in Federal or State laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by Federal Regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer.

A COPY OF THE ENTIRE PRIVACY PRACTICE POLICIES IS AVAILABLE UPON REQUEST.

I have been given and read the notice of Privacy Practices for Therapy Center Counseling and Consultation.

_____

Printed Name of Patient DOB

_____

Signature of Patient or Parent/Legal Guardian Date

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Informed Consent:

Therapy Center Counseling and Consultation is a private counseling office. Audio or video recording inside or within 100 yards of Therapy Center Counseling and Consultation is strictly prohibited. Anyone choosing to video or record on Therapy Center Counseling and Consultation premises will be asked to leave and will not be allowed to return. Counseling is a very private and personal decision and there is zero tolerance for anyone deliberately violating this policy.

Further, it is the policy of Therapy Center Counseling and Consultation that we do not interact with patients of Therapy Center Counseling and Consultation on social media. There is a general Therapy Center Counseling and Consultation Facebook page that will be used to provide general updates about office hours but does not have messaging capabilities and should not be used to communicate with the staff at Therapy Center Counseling and Consultation.

As a patient at Therapy Center Counseling and Consultation, you have a patient/ therapist privilege but, there are certain exceptions to that rule. Everything that you share in therapy is confidential unless:

1. You give verbal or written consent for information to be released.
2. You make threats of self-harm or harm to others.
3. You inform someone in this office that you know that a minor is in some type of danger or being harmed. We are state mandated reporters.
4. A superior court judge orders us to release the documents due to a court referral, civil action, or criminal behavior.
5. If you are referred by a judge or a medical doctor, Therapy Center Counseling and Consultation will communicate, with the referral source to give a summary of your care, progress report, & recommendations. Please understand that court appearances and consultations are not covered by insurance and will be billed directly to you.

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You may revoke this consent at any time by speaking directly with your counselor and signing the appropriate paperwork.

By signing this document, you are agreeing to receive counseling services at Therapy Center Counseling and Consultation and therefore consenting to the above listed practices.

I consent to the above listed practices and will speak to my counselor if I choose to revoke any aspect of this consent.

_____

Printed Name of Patient DOB

_____

Signature of Patient or Parent/Legal Guardian Date

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Name:_____Date:_____

Do you have any problems at this time?

Please check any symptoms that describe how you feel, think, or behave currently or during the past few weeks:

( ) Abdominal pain
( ) Agitation
( ) Avoidance of public places
( ) Change in ability to walk
( ) Chest tightness
( ) Confused/worried about sexual behavior
( ) Crying episodes
( ) Difficulty at work
( ) Difficulty concentrating
( ) Difficulty functioning socially
( ) Difficulty waiting your turn
( ) Easily startled
( ) Excessive spending
( ) Fainting
( ) Fear of leaving home
( ) Fearfulness
( ) Frustration
( ) Hopelessness
( ) Irritability
( ) Loss of appetite
( ) Marital conflict
( ) Multiple sexual partners
( ) Muscle weakness
( ) Neck pain
( ) Aggressive/abusive towards others
( ) Attempts to harm self
( ) Back pain
( ) Chest pain
( ) Chronic sadness
( ) Constipation
( ) Diarrhea
( ) Difficulty completing tasks
( ) Difficulty focusing
( ) Difficulty making decisions
( ) Dizziness
( ) Excessive gambling
( ) Excessive worry
( ) Fear of dying
( ) Fear of loss of control
( ) Frequent forgetfulness
( ) Hard to stay with job very long
( ) Intrusive thoughts of bad memories
( ) Legal problems
( ) Low energy/fatigue
( ) Memory problems
( ) Muscle stiffness
( ) Nausea/vomiting
( ) Nightmares

( ) Not well organized
( ) Panic attacks
( ) Pounding heart/palpitations
( ) Racing thoughts
( ) Re-living bad experiences
( ) School problems
( ) Seizures
( ) Shortness of breath
( ) Snoring
( ) Taking on too many tasks
( ) Thoughts of physically hurting others
( ) Trembling/shaking
( ) Withdraw from others

( ) Overeating
( ) Physical abuse
( ) Problems with co-workers
( ) Reduced interest in activities
( ) Restlessness
( ) Seeing things others don't
( ) Sexual abuse
( ) Sleep problems
( ) Staying up for days without sleep
( ) Tendency to act impulsively
( ) Thoughts of suicide
( ) Vision changes

Please describe why you are seeking help at this time

Has any member of your family been hospitalized for mental health concerns? _____
If yes, please list who, when, and for what reason:

Do/did you have any family members who have/had problems with drinking alcohol or using drugs? _____
If yes, please list who, when and if it is still a problem:

Has any member of your family attempted/committed suicide?_____
If yes, please list who, when, and what happened:

What is your best memory about your family when growing up?

If you could change anything about your family situation right now, what would it be?

Have you ever seen a counselor, psychologist, psychiatrist, or other mental health professional for any mental health or drug/alcohol concerns?_____
If yes, please list who, when and why:

Have you ever been hospitalized for mental health or drug/alcohol concerns?_____
If yes, please list when and for what reason:

Do you have thoughts of harming yourself?_____

If so, how often does this happen?_____

Have you ever tried to harm yourself?_____

If so, when did this happen?_____

Did you receive medical help at the time?_____

Current Medications

(Please include prescription, over the counter, herbs, vitamins, and other remedies)

Medication Prescribing Doctor	Dosage/when taken	Reason taking

Allergies to medications:_____

_____

Please list any current medical problems or concerns:_____

_____

_____

Please list any past serious illnesses, surgeries or health concerns:_____

_____

_____

Exercise and Physical Recreational Activity

Type of activity How often

_____

_____

_____

Would describe yourself as physically active?_____

Do you currently have a primary care physician? _____

If so, please list his/her name: _____

Are you currently under the care of any other physicians? If so, please list names:

_____

_____

Use of substances (on average)
If none, please leave blank.

	Current amount	**Most used in past**
Alcohol	_____ glasses per day _____ glasses per week	_____ glasses per day _____ glasses per week
Tobacco	___cigarettes _____ per day ___ cigars _____ per day ___smokeless ___cans per day	___cigarettes _____ per day ___ cigars _____ per day ___smokeless ___cans per day
Caffeine (tea, coffee, soda)	_____ servings per day	_____ servings per day
Marijuana	_____ per day _____ per week	_____ per day _____ per week
Cocaine	_____ times per day _____ times per week	_____ times per day _____ times per week
Diet pills **Name:_____**	_____ pills/doses per day _____ pills/doses per week	_____ pills/doses per day _____ pills/doses per week

Marital status:_____ Children:_____
Education:_____
Living arrangements:_____
Employment:_____
Military service:_____