



The Clarity Psychological Group

3915 Cascade Rd. SW Suite 250

Atlanta, GA 30331

(404) 699-3170

Dear Client:

It is a pleasure to have you in our practice. We appreciate the opportunity to work with you. In order to avoid any discord or misconceptions in the future, this letter has been prepared for your information.

Informed Consent: Before obtaining any counseling care, it is important to gain sufficient knowledge regarding the types of treatment available, any risk, and potential benefits. This process of information gathering is known as receiving “informed consent”. Although we will not make decisions for you, we will, however be available to assist you in making alterations and understanding their impact on you and others. We will always keep you informed of any changes in therapy that we may propose and any risks we foresee. In addition, we may suggest alternatives to therapy so that you can make well-informed decisions about your treatment.

INITIALS _____

Appointments/Payments: This office operates on an appointment basis. In order for your time to be reserved, it is essential that you make appointments in advance. Each appointment is a clinical hour, which is 50 minutes. If you need to cancel an appointment, please do so at least 24 hours in advance, so that you will not be charged for the session. **A \$50.00 fee will be assessed for appointments cancelled within 24 hours of the scheduled visit.** If for any reason, you need to cancel your appointment, you are responsible for making contact with our office. You may leave a message with our answering service or voice mail, and you may also email us at claritypsychgroup@gmail.com. Although we may not receive the notification until the following business day, we will refer to the time-stamp. Documented efforts **MUST** be made in order for your cancellation fee to be waived.

INITIALS _____

A "No Show"/ missed appointment for a scheduled appointment will incur a \$50.00 fee. This fee will be due and payable directly from the client and will not be billed to your insurance company. **Clarity Psychological Group clients are required to provide a credit/debit card to be held on file in our secure database to ensure a guarantee of payment in the event of “No-Show” or cancellation within 24 hours.** We have had trouble collecting fees, and as a result we have been forced to implement this change. You will be notified of the cancellation/no show fee at the time of the missed appointment, and of the charges applied to your account. You will also be notified via e-mail and sent a receipt for the transaction. This fee must be paid before any further counseling sessions will be allowed. *This in no way will compromise your ability to dispute a charge or question your insurance company’s determination of payment.*

As a courtesy, you may receive a call or email from our office confirming your appointment. The call/email may occur within 24-72 hours of your scheduled appointment. ***This is a courtesy of our office. If you do not receive a courtesy call/email reminder, you are still expected to arrive as scheduled for your appointment.***

INITIALS _____

Termination of Services: It is your right to terminate our relationship at any time. We would appreciate a one-week notice so that we might meet to discuss the termination and your future plans. At that time, we can assist you in locating another counselor and you may authorize the transfer of your records if necessary.

INITIALS _____

Confidentiality: With few exceptions, our conversations are confidential. State law, federal regulations and our Code of Ethics specifically guarantee this confidentiality. There are some situations however, in which confidentiality cannot be guaranteed. They fall within the following categories:

1. We must notify appropriate persons if we feel that a client may harm him/herself or another individual. (This is our duty to warn.)
2. We must report the abuse, neglect, or exploitation of children or the elderly.
3. We are required to respond to a subpoena accompanied by a court order.
4. We conduct periodic peer reviews of client cases for best professional practices as well as for supervision purposes.

INITIALS _____

Emergency Procedures: We are committed to being responsive to your needs. However, there may be times when we are unavailable. If you need immediate help, you should contact one of the resources below:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Ridgeview Institute at 770-434-4567
- Call Peachford Hospital at 770-454-5589
- Call Lifeline at 800-273-8255 (National Crisis Line)
- Call 911
- Go to the emergency room of your choice.

Billing and Insurance: The fee for counseling services may be up to \$150.00 for each clinical hour. Self-pay clients are responsible for the session fee at the time services are rendered. If you have insurance coverage, we will be happy to assist you in filing claims on your behalf. Rates may change at any time; however, we will do our best to notify you in advance of any changes.

When insurance is used, a co-payment or full payment of the session (depending on plan deductibles) may be required. Client payments are dictated by your insurance company. All client payments are due at the time of each session.

INITIALS _____

Disability/Personal Client Paperwork: All disability and other related forms received in this office from your insurance company, or otherwise received on your behalf to be completed by your therapist, **may incur a service fee up to \$200.00 per occurrence. Any follow-up, second-tier, dispute, or additional set of forms may incur an additional fee up to \$200.00.** All fees must be paid in advance by the client. Fees are not billable to an insurance company or Employee Assistance Program (EAP). **Forms may only be completed during a scheduled office visit.**

INITIALS _____

Telecommunication Informed Consent

See our Authorization and Consent form for telemental health information.

If you have any questions about office procedures, therapy options, or other issues, please ask at any time. We look forward to working with you to assist you in “Bringing Clarity to confusion”.

I have read the above letter and agree to abide by all the terms. I agree to enter into counseling with The Clarity Psychological Group. The benefits and risks of therapy and the duty to warn have been explained. I understand that it is my decision to continue therapy and that I may terminate at any time. I have been provided the opportunity to discuss any questions with my clinician and or staff, and my questions have been answered to my satisfaction.

Printed Name of Client

Date

Signature of Client

Date

Printed Name of Client

Date

Signature of Client

Date

Signature of Therapist

Date

Clarity Psychological Group
Informed Consent: Interaction with the Legal System

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litem, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record, and I will be responsible for charges in producing that record.

If I believe it necessary to subpoena my therapist to testify at a deposition or a hearing, I would be responsible for his or her expert witness fees in the amount of \$1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day would be billed at the rate of \$375.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

Printed Name of Client

Date

Signature of Client

Date

Printed Name of Client

Date

Signature of Client

Date

Signature of Therapist

Date

The Clarity Psychological Group
CREDIT/DEBIT CARD AUTHORIZATION FORM

It is a policy of this practice to keep a credit card on our secure database in case of a “no show” visit (late or no cancellation). Your credit card information will be protected along with the rest of your information. You may also choose to have this credit card charged with your regular session fees.

Patient's Name: _____

Cardholder's Name: _____

Credit Card Billing Address: _____

City, State and Zip Code: _____

Credit Card Type (Circle One): Visa Mastercard American Express Discover

Credit Card Number: _____

Expiration Date: _____ / _____ CCVS/CVC2/CID: _____

I have read and agree to the office's policy of keeping my credit card information on file. This information may be used for payments of past due balances and/or no show visits. Regular fees will be charged with my verbal permission. I understand that this authorization will remain in force until termination of therapy, which MUST be done via a termination session, phone call, or in writing. I understand my card will be charged even if I terminate sessions after my scheduled appointment and that I must cancel my appointment 24 hours before my session to avoid the no show fee.

Authorized Signature: _____ Date: _____

Client Information

(Must be completed before services can be rendered)

Name: _____
 First Middle Last

Address: _____
 Street Apt City State Zip

Email: _____

Best contact number: _____ Alternate: _____

Sex: Male Female Date of Birth: _____

Marital Status _____

Employer _____

Employer Address _____

In case of emergency, notify: (Name) _____

Phone _____ (Relationship) _____

Primary Insurance / (Responsible Party's Information)

Name of Carrier _____

ID# _____

Name of Insured: _____ Insured's Date of Birth: _____

Social Security Number (Tricare only): _____ Phone: _____

We do not file with secondary insurance companies.

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of mental health benefits directly to The Clarity Psychological Group. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed _____ Date _____

Client Intake Survey
The Clarity Psychological Group, LLC.
3915 Cascade Road Suite 250
Atlanta, Georgia 30331

Name: _____ Date: _____ Birthday: _____ Age: _____

How were you referred to us?

- Primary Care Doctor
- Inpatient Hospital
- Friend or Family
- Psychology Today
- Facebook
- Other: _____

What type(s) of counseling are you seeking?

- Individual
- Couples
- Family

Have you ever participated in counseling before?

- Yes
- No

If yes...

When was your last session? _____

Please list the name of your previous therapist: _____

What was the purpose of your treatment? _____

Have you ever received any psychiatric treatment?

- Yes
- No

Have you ever received drug or alcohol treatment?

- Yes
- No

Have you ever been hospitalized for mental health concerns?

- Yes
- No

Please describe your sleep patterns including the number of hours that you sleep each night:

Please describe your eating habits:

Have your eating habits changed over the last 6 months? If so, in what way?

If you answered yes to any other the previous questions, please explain below:

Please provide your current and past medical history below:

Medical Diagnosis/Issues	Current Treatment/ Medicine

Please list all medications, vitamins and supplements that you are currently taking:

Medication/ Drug	Dose	Frequency	Reason for taking/ Response to medication

List any drug allergies or adverse medical reactions:

Please indicate with a (√) if you have used or currently use the following substances.

Drug of Choice	Current/Previous Use	Frequency of Use
Alcohol		
Drugs		
Tobacco		
OTC		
Other		

In the past month, has anyone complained to you about your drinking?

- Y
- N

Have you ever thought that you may need to change your drinking habits?

- Y
- N

Do you ever have trouble remembering how much you've had to drink?

- Y
- N

Family of Origin

Relative	Name	Current age (or age at death)	Physical and/or Mental Health Illnesses (cause of death if deceased)	Relationship (excellent, good, fair, poor)
Mother				
Father				
Brothers and Sisters				
Others: (step parents or siblings, grandparents, etc.)				

Describe the emotional atmosphere in your childhood home:

Education:

Did you graduate from high school or receive a GED?

- Yes
- No

If yes, where did you attend? _____

Did you graduate from college or technical school?

- Yes
- No

If yes, where did you attend? _____

Did you attend any graduate school?

- Yes
- No

If yes, where did you attend? _____

Do you have any special skills or trades? If yes, what are they?

Employment:

Current Employer: _____

- FT
- PT

Current issues with work?

- Yes
- No

If yes, please explain:

Are you applying for/intend on applying for disability or workman's compensation?

- Yes
- No

If yes, please explain:

Stress level at work

- Low
- Medium
- High

How long have you been with your current employer?

- 0-6 months
- 6 months-1 year
- 1-5 years
- 5-10 years
- Over 10 years

Are you experiencing any legal issues?

- Yes
- No

Are you experiencing any financial issues?

- Yes
- No

Military experience and/or combat experience

- Yes
- No

Social Information

Please indicate your current marital/relationship status:

- Married
- Single
- Separated
- Divorced
- Widowed
- Living with partner

Do you have children?

- Yes
- No

If yes, please note first names and ages below:

Describe the relationship with your spouse/partner?

What are the strengths of your relationship? What are the weaknesses?

What would you like your therapist to know as she develops your treatment plan?

Thank you for completing intake form. Please return completed packet to the front desk.