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:______________________

Social Security Number: ____________________ Sex: Male ☐ Female ☐

Marital Status________ Date of Birth: ___________

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 #: _______________________ 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____________

The receptionist will need to copy your insurance cards and driver's license. Please present them to the receptionist with this completed form. Thank you.

The Clarity Psychological Group

3915 Cascade Rd. SW
Suite 250
Atlanta, GA 30331
(404) 699-3170 (Phone)
(404) 699-5680 (Fax)

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.

Appointments: This office works 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. 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. This fee must be paid before any further counseling sessions will be allowed.

As a courtesy, you *may* receive a call from our office confirming your appointment. The call may occur within 24 - 48 hours of your scheduled appointment. *This is a courtesy of our office.* If you do not receive a courtesy call reminder, you are still expected to arrive as scheduled for your appointment.

Termination of Services: It is your right to terminate our relationship at any time. We would appreciate 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 can authorize the transfer of your records, if necessary.

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 themselves or another individual. (This is our duty to warn.)
2. We must report child abuse, or the abuse, neglect, or exploitation of the elderly.

3. We are required to respond to a subpoena accompanied by a court order.

Emergency Procedures: We are committed to be responsive to your needs. However, there may be times when we are unavailable. If you need immediate help, you should call the emergency mental health number for your county, go to the mental health hospital nearest you, or go to your hospital emergency room. For extreme emergencies, you should call 911.

Billing and Insurance: The fee for counseling services is up to $125.00 per clinical hour. Payment is due, in full, at the time of each session. If you have insurance coverage, we will be happy to assist you in filing claims on your behalf.

When insurance is used, a co-payment or full payment (depending on plan deductibles) may be required by your insurance company. Client payments are dictated by your insurance company. All client payments are due at the time of each session. If your payment is rendered by personal check and your check is returned, an **NSF** (non-sufficient fund) **fee of $25 and the original amount of the check** are required prior to being seen by a therapist. The NSF fee and amount of the check must be rendered with cash or credit card.

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, will incur a **$200.00 service fee per occurrence**. Any follow-up, second-tier, dispute, or additional set of forms will incur an additional $200 fee. All fees **must** be paid in advance by the client. Fees are not billable to an insurance company or Employee Assistance Program (EAP). Forms can only be completed during a scheduled office visit.

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 and anticipate that our relationship will be mutually beneficial.

_________________________________ __________________

Therapist Signature Date

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.

____ ____________________

Client Signature Date

____ ____________________

Client Signature Date

The Clarity Psychological Group

3915 Cascade Rd. SW
Suite 250
Atlanta, GA 30331
(404) 699-3170 (Phone)
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Patient Confidentiality Statement
Signature Page

This certifies that as a patient with The Clarity Psychological Group, I have read and fully understand the Our Patient Confidentiality Statement. A copy of this document may be given to me upon my request.

Signature____Date__________________

Employee Assistance Benefits/ EAP

EAP Provider Name: ____

Authorization Number: ____

Number of Visits: ___________________________

Prior to a scheduled appointment, we ask all clients to give us at *least 24 hours notice* if the appointment is to be rescheduled or cancelled. EAP clients are allotted one (1) incident of a less than 24-hour cancellation notice **or** no-showing for a scheduled appointment. A second such incident will result in The Clarity Psychological Group uninviting the client to the practice and notifying the sponsoring EAP firm that we no longer provide EAP counseling for the client. Please refer to your EAP agreement for potential actions your provider may impose for missed appointments.