Ken Scroggs, LCSW, LPC, LMFT, CEAP, DCC
Thommi Odom, PMP, PHR, CGC

Date ____Appointment Time_4:00 pm

Dear New Client,

Welcome to the North Pines Center. We want our services to be the most helpful so that your experience will be the very best. To optimize your care please consider what it means to make a commitment to your therapy and a therapeutic relationship.

Psychotherapy is empowering. Psychotherapy is a special kind of healthcare and aims to assist you in developing clear goals, enhancing interpersonal skills and improving your lifestyle. Some examples of the interpersonal skills often discussed in therapy may include communication skills, focused attention, relaxation exercises and trying new or different thoughts, feeling and behaviors. You may also be encouraged to keep a log or journal of these new experiences, prepare questions in advance of your sessions and conduct home work assignments. You may make audio recordings of your sessions as more issues may be addressed than one can absorb. You may also be invited to participate in support groups when appropriate. We want to empower you to improve your life, relationships and well- being.

Confidentiality. Psychotherapy and counseling are confidential services and you can expect that your therapist and our staff will do everything possible to maintain your privacy. However, for billing insurance we will need you to complete a portion of the attached insurance form and sign the privacy statement to permit us to communicate with your insurance company. It would also be necessary for you to sign a release of information allowing your therapist to consult with your physician if necessary. Your therapist will not communicate with anyone without your consent except as required by Georgia Law such as child abuse or threats of violence.

Please complete the Client Data Intake (first page) and the highlighted portion of the Health Insurance Claim Form and Statement Card. We also take Visa and MasterCard for your convenience. We will also need a copy of your insurance card. Please feel free to ask your therapist or our staff questions about our services.

Cancellation; By calling 24 hours in advance to cancel your appointment you will **avoid paying the $125 for initial assessment or $100 fee for follow-up appointments.** Please initial that you agree to pay for all appointments you make including late calculations (24 hours notice please). If you have read and understand this form, please initial here _____.

Sincerely,

Ken Scroggs, LCSW, LPC, LMFT, CEAP
Thommi Odom PMP, PHR, GCC

NORTH PINES CENTER

STATEMENT OF UNDERSTANDING and NOTICE OF PRIVACY

STATEMENT OF UNDERSTANDING

The North Pines Center – Scope of services.
Then North Pines Center is a private, out patient mental health treatment center offering help and assistance by providing assessments, counseling and referrals for individual, relationship and families. The services offered by the North Pines Center are provided at a cost to be paid by the client. In some cases insurance may pay a portion of the cost, but it remains the responsibility of the client to insure their bill is paid in full. Your counselor will help you to assess your problem and develop a plan of action.

NOTICE OF PRIVACY
Confidentiality and Release of Information – Description of medical information disclosure.

Confidentiality. The information you give your counselor is CONFIDENTIAL except in the following exceptions; when you give written authorization such as requesting your counselor speak with your physician. It is not confidential if you threaten to harm yourself or others such as suicide, homicide, child abuse, spouse abuse or threats of violence toward a co-workers. When there is a valid court order. When a crime is committed by the client at the North Pines Center, or against any person who works for the North Pines Center or when there is a threat to commit a crime. For research, evaluations or teaching purposes with you written permission. The federal laws that protect your health information are the Health Insurance Portability and Accountability Act of 199 (HIPAA) and the Confidentiality Law 42 U.S.C.290dd-3 and C.F.R. part 2 for federal regulations. Under these laws, the North Pines Center and your counselor may not inform others that you attend a counseling or disclose any other protected information except as permitted by your signature or federal and state laws as noted here. If you wish to make a complaint, you are encouraged to contact the director of the program Ken Scroggs or Secretary of the United States Department of Health and Human Services. Under HIPAA you have the right to inspect and copy the health information maintained EAP Works except to the extent that the information contains psychotherapy notes or information compiled for use in civil, criminal or administrative proceedings or in other limited circumstances. You also have the right, with some exceptions, to amend health care information.

Duties. The North Pines Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy with respect to your health information.

ALL CLENTS PLEASE SIGN
By signing, I understand the North Pines Center services, confidentiality and duties.

Client Signature ____ Date __________

Counselor Signature ____ Date __________

Quality Care. With your consent the North Pines Center staff may follow up with you to insure you are well served and your issues are resolved. This contact will also assist us with monitoring and improving the quality of the program. Initial ______

Patient Bill of Rights and Responsibilities

Welcome to North Pines Center, Inc. We are committed to providing the highest quality care possible.

Patient Rights

I have a right to efficient and effective care individualized to my needs. My treatment provider will work with me to develop a treatment plan best suited to me. We will use this plan to help us deal with my problems as quickly and effectively as possible.

I have the right to be treated with dignity and respect. I will be treated with respect at all times. I will report any misconduct by my treatment provider to North Pines Center Director and/or the appropriate state agency. I may call North Pines Center at any time with questions, comments, or complaints.

My treatment provider will make every effort to meet with me at our scheduled appointment time.

I have a right to privacy and confidentiality. All records and communications about me will be treated confidentially in compliance with applicable state and federal laws. These laws may obligate North Pines Center to report suspected abuse or neglect, and those who pose a danger to themselves or others.

Patient Responsibilities:

Financial Policy. Full Payment for non-covered services, co-pays and co-insurance are due at the time of service. We accept Cash, Checks, Visa and MasterCard. If your Insurance company has not paid your account in full within 90 days, the balance of your account will be your responsibility.

Scheduled appointments are commitments. I will make every effort to be on time for my appointment (s). If I am late for my appointment, I understand that time will be lost from my session. If I miss an appointment and do not notify my treatment provider at least 24 hours in advance, I understand I will be charged a missed appointment fee of $100.00.

My health is my responsibility. I may contact my treatment provider for any emergency situation that arises, such as suicidal or homicidal thoughts, even if after normal office hours. I understand that I am financially responsible for emergency care when not covered by insurance.

I have read this list of rights and responsibilities. I understand and agree to them.

______________________ ______________________ ____________

Print Name Patient Signature Date

NORTH PINES CENTER
Intake Data Form

Client Name: ________________________ Date: __________________________

Address: ________________________________ City/St/Zip: __________________________

Home Phone: _____________________ Work Phone: _____________________ Sex: ❑ M ❑ F
Cell Phone: ______________________ Email: ___________________________
Date of Birth: _________________ Soc. Sec. #_____-____-___
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other: ____________________
Spouse Name: ____________________________ Phone: (H) _____________ (W) __________
Children (include ages): ____
Who currently lives at home with you? ____

Referral source____

Education: ❑ Grade 1-12 ❑ High School Grad or eq. ❑ Some College
❑ College Grad ❑ Masters Degree ❑ Doctorate ❑ Other: ________________
Race: ❑ African Amer. ❑ Caucasian ❑ Hispanic ❑ Asian
❑ Native Amer. ❑ Other: ________________________

Job Category: (please check)
❑ Admin/ Mgmt. ❑ Prof/Tech ❑ Clerical ❑ Sales/Mktg ❑ Maint/Operations
❑ Labor/Mfg. ❑ Other _______________________________

MEDICAL INFORMATION:
Name of Doctor: _____________________________________ Phone: ___________________
Insurance: ____ Group #: __________________

Alcohol/Drug Use: ❑ None ❑ 1-3 Times/wk ❑ 3-7 Times/wk ❑More: ___
❑ Weekends only ❑ Usually drink alone ❑ Blackouts
❑ DUI/Legal ❑ Job problems due to Alcohol/Drug use

General Health: ❑ Excellent ❑ Good ❑ Average ❑ Poor
Eating Habits: ❑ Excellent ❑ Good ❑ Average ❑ Poor
Sleep Patterns: ❑ Excellent ❑ Good ❑ Average ❑ Poor

Do you experience symptoms of anxiety or depression? ❑ Yes ❑ No ❑ Sometimes
Symptoms: ____

History of Previous Counseling: ❑ None ❑ Psychiatrist ❑ Psychologist
❑ Social Worker ❑ Counselor ❑ Marriage/Family Therapist

Describe your goals for counseling: ____
____

Your cooperation in scheduling appointments is greatly appreciated. To avoid being charged for missed appointments, please give a 24hr. notice. NOTICE: If you do not cancel in advance you will be responsible for paying the full fee of $125 for initial assessments or $100 for follow-up appointments. Also, if you have scheduled future appointments you will be responsible for all payments unless you advise us otherwise.
Please read and initial. Client______ Counselor_______