Counseling Institute of Atlanta, Inc.
Bilingual & Multicultural Mental Health Services
5855 Jimmy Carter Blvd., Suite 200, Norcross, GA, 30071
Office: (404) 630-1361 / Fax: (770) 441-9177

ADULT HISTORY- INTAKE FORM
(MENTAL HEALTH EVALUATION)

I. DEMOGRAPHIC INFORMATION

Name: ____ Date: ________________

Age: ______ Date of Birth: ____________ Place of Birth (Country and City): ______________________ Gender: _____

Address: ____________________________ City: ___________________ State: _________ Zip code: ________

Ethnicity/Race: [ ] Hispanic/Latino [ ] White [ ] African American [ ] Asian Other: __________

Cell Phone: _________________________ Email: ______________________________________

Calls will be discreet, but please indicate any restrictions: ___________________________________

In case we need to call you, can we leave a voice/text message? Yes [ ] No [ ]

How long have you been living in the United States? ______________________ How long in the State of Georgia? ________

Person(s) to notify in case of any emergency: _______________________________ Relation to you: ______________
Name Phone

Do you speak other languages other than English? Yes [ ] No [ ] If yes, please mention which one (s): ________________

Date in which you became a United States citizen or permanent resident: ________________________________

Referred by (person who is helping you through the legal process): _________________________________

Reason (type of legal process): ____

II. REASONS TO LOOK FOR COUNSELING

Transportation to Interview: [ ] Alone [ ] Parents [ ] With Others [ ] Drove [ ] Driven [ ] Taxi [ ] Public Transportation

Please, briefly describe your present concern(s) due to the current immigration or legal process: ________________________

____

____

____

____

____

____

____

____

III. CURRENT SYMPTOMS/ COMPLAINTS CHECKLIST

Please check all that apply and circle the main problem:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Concerns			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating With Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

Any additional information you would like to include: ____________________

IV. FAMILY HISTORY

Marital Status: [ ] Separated [ ] Single [ ] Partnered [ ] In a relationship [ ] Divorced [ ] Married [ ] Widowed

Name of spouse or partner (if applicable): ____________________ Age: __________

Originally from (Country and City)? ____________________ Dating since? __________ Date of legal marriage __________

How long has your spouse been living in the United States? ____________________

Have you been previously married/ life partnered? Yes [ ] No [ ] How many times? ____________________

If so, length of previous marriages/committed partnerships____

Did you suffer from domestic violence in your previous relationship(s)? ______________________________________

Did you have children in your previous relationship(s)? [ ] Yes [ ] No How many? _______________________

If so, briefly describe the relationship between your spouse and your children:

____

____

Does your spouse have children from a previous relationship(s)? Please describe briefly your relationship with them:

____

____

List all your children (in your current and previous relationship). If your spouse has children from a previous relationship, please include their names in this list too:

Name	***Sex***	***Age***	***Biological or Adopted***	***Living with you?***	
				yes	No
				yes	No
				yes	No
				yes	No
				yes	No
				yes	No
				yes	No

Language spoken with children: ____

Who are you living with? ____

In which city do your parents live? ____

How would you describe your relationship with your parents? _________________________________

If they ever divorced/separated, how old were you when they separated or divorced, and how did this impact you?

____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have

impacted your life: ____

How would you describe your relationships with your siblings? ________________________________

In which city do your siblings live? ____

V. EMOTIONAL/ MENTAL HEALTH TREATMENT HISTORY

Prior outpatient psychotherapy or counseling? [ ] Yes [ ] No How long, where, and when? _______________

____

Prior inpatient treatment for a psychiatric, emotional or substance use disorder? [ ] Yes [ ] No

If yes, specify length of treatment and time period below ______________________________________

Prior psychological evaluations? [ ] Yes [ ] No If yes, when, where and why

____

Past suicide thoughts/ attempts? Yes [ ] No [ ] Current suicide thoughts? Yes [ ] No [ ]

Past homicidal thoughts/ attempts? Yes [ ] No [ ] Current homicidal thoughts? Yes [ ] No [ ]

If history is positive for suicide or homicidal ideation / attempts, please describe incident and date:

____

Check all that apply; please indicate if it is a current or past situation.

	Now	Past		Now	Past		Now	Past
Drug/Alcohol Problems			Physical Abuse			Depression		
Legal Trouble			Sexual Abuse			Anxiety		
Domestic Violence			Hyperactivity			Psychiatric Hospitalization		
Suicide			Learning Disabilities			"Nervous Breakdown"		

Please briefly describe any history of abuse, neglect and/or trauma or emotional injuries: ____________________

____

VI. MEDICAL HISTORY

Describe Current Physical Health : [ ] Good [ ] Fair [ ] Poor

Please explain any past or current significant medical problems, symptoms, or illnesses (head injuries or other neurological problems):

____

____

Describe past major surgical history: ____

Due to this immigration/legal process, have you presented any type of symptom out of the ordinary?

____

Prior/Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

VII. SUBSTANCE USE HISTORY

Have you ever consumed alcohol or recreational drugs in a way that may have affected your everyday activities or relation with family, friends, or coworkers? Yes [ ] No [ ]

If Yes, please describe which substance you consumed and how often:

____

Have you ever been in trouble or in risky situations because of your substance use? Yes [ ] No [ ]

Describe any past treatment for substance use?

____

____

Currently using substance(s)? [ ] Yes [ ] No

Consequences of Subtance Use (Check all that apply):

[ ] hangovers
[ ] withdrawal symptoms
[ ] sleep disturbance
[ ] arrests
[ ] seizures
[ ] medical complications
[ ] assaults
[ ] DWIs
[ ] blackouts
[ ] tolerance changes
[ ] suicidal impulse
[ ] tremors
[ ] overdose
[ ] loss of control amount used
[ ] relationship conflicts
[ ] drinks to the point of intoxication
[ ] job loss
[ ] binges

Explain any items checked:

____

____

VIII. EDUCATIONAL HISTORY

List your highest grade in school or college/degree achieved, school name, and city/country where you studied.

____

Do you plan on continuing your studies? If so, please explain how long would it take to accomplish them and how your schedule and financial situation could change ____

____

IX. OCCUPATIONAL/ EMPLOYMENT HISTORY

Previous job (responsibilities, full-time or part-time, how long) ______________________________________

What is your current employment? (Please, describe your responsabilities, is it full-time or part-time, the name of the company, do you have benefits, how long have you been working here, how much is your monthly salary, etc.)

____

____

____

Check all that apply:

[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflicts
[ ] unstable work history
[ ] disabled
[ ] medical disability
[ ] supervisor conflicts
[ ] on the job stress
[ ] sexual harrasment at work
[ ] discrimination at work

Military History: [ ] never in military [ ] served in military-no incident [ ] served in military-with incident [ ] combat experience

Branch & Rank Locations Dates Age Discharge

____

____

X. CURRENT & PAST LEGAL HISTORY

Any past arrests or legal problems? Describe where, for which reasons, and how much time you were incarcerated:

____

____

____

XI. SOCIO-ECONOMIC HISTORY

Financial situation (Please describe if you depend on somone else to cover your expenses or if someone depends on you):

____

____

Social / Family support system: ____

Spiritual or religious practice: ____

Recreational/ hobbies, interests & leisure activities: ____

____

XII. DEVELOPMENTAL HISTORY

In a few words, describe your childhood and adolescence (Major issues, concerns):________________________

____

____

____

List what best describes your childhood and explain if applicable:

____ Emotional problems
____ Drug abuse
____ Medical problems
____ Witnessed domestic violence between parents
____ Physically abused
____ Sexually abused
____ Other problems: ______________________________

____ Eating disorders
____ Problems in school
____ Family problems
____ Legal problems
____ Behavioral problems
____ Alcohol abuse
____ No major issues during my childhood

Additional Information:

Anything else about your case you would like to mention or emphasize (recollection/ description of the event: dates, times, locations, witnessess, what happened before, during, and after the event)? [ ] Yes, describe [ ] No

Counseling Institute of Atlanta, Inc.

Bilingual & Multicultural Mental Health Services

INFORMED CONSENT FOR COUNSELING SERVICES

Welcome to the Counseling Institute of Atlanta, Inc., for Counseling Services. Thank you for trusting us to assist you with your concerns. It is our desire to help you in this moment of your life. We are honored that you have chosen one of our therapist. We will do everything we can to help you move forward and solve your problems.

This document is designed to inform you about what you can expect from your therapist, policies regarding confidentiality and emergencies, and several other details regarding your treatment here at the Counseling Institute of Atlanta. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist or group leader is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Background Information, Theoretical Views, & Client Participation

Information regarding your therapist's educational background and experience may be found on our website under his or her name. Please feel free to view that information at www.counselinginstituteofatlanta.com.
It is our belief that as people become more aware accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months of therapy. As a client, you are in complete control, and you may end your relationship with your therapist at any point.
In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.
Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without your therapist. We also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit.

TERMINATION OF THERAPY: Each stage of therapy has important ramifications for the client's motivation, growth and self-esteem. Termination, although an ending of therapy, is a part of the development of the therapeutic relationship. A client who misses more than two sessions without notifying the therapist should be seen as initiating a premature termination. The staff from the Counseling Institute of Atlanta will try to contact you, but your case will be terminated/closed if we do not hear back from you for one month. If you are feeling better or planning not to return to therapy, it is important that you come in for a final session, so that we can discuss the reasons leading to the decision, the course of therapy and any relevant referrals. A case is considered terminated when there is no longer any regular sustained contact following a specified treatment plan. However, reopening your chart and resuming treatment is always an option.

SERVICE SATISFACTION/ RESEARCH: I understand that the Counseling Institute of Atlanta, Inc may occasionally collaborate with colleges and universities to provide training to masters and doctoral level students by serving as a practicum/internship site. All interns are supervised by senior level staff (Licensed Professional Counselor, Licensed Clinical Social Worker, Psychiatrist or Licensed Psychologist). If you prefer not to work with a graduate trainee, please speak with your therapist or the receptionist. The Counseling Institute of Atlanta, Inc may also at times collect information about your experiences in treatment to inform and potentially improve our ability to deliver high quality services. As part of this effort we may ask clients to complete a brief evaluation, survey, or questionnaire on a voluntary and anonymous basis. If you have any questions, please speak with your therapist or the receptionist.

Confidentiality & Records

Your communications with your therapist will become part of a clinical record of treatment, which is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our locked office and/or will be stored electronically with a mental health and therapy notes software, a secure storage company who has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, Federally approved encryption.

Your therapist will always keep everything you say to him or her completely confidential, with the following exceptions: (1) you direct your therapist to tell someone else and you sign a "Release of Information" form; (2) your therapist determines that you are a danger to yourself or to others, we may be required to take protective action, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization.; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; (4) to obtain appropriate professional consultations; (5) to obtain payment for services, in which instance the disclosure is limited to the minimum that is necessary to achieve the purpose or (6) your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. This state has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential.

As mentioned before, to release information about your therapy, we need to have written releases from you. In general, the law protects the confidentiality of all communications between clients and counselors. We only release information about our work with your written releases. Clients often give me releases to talk to their individual therapists, and/or previous therapists. This helps us to coordinate your therapy so that it will be most helpful to you.

Occasionally, we find it helpful to consult with other professionals about a situation in therapy. In these consultations, we avoid revealing the identity of my clients. We will usually inform you of these consultations.

Please note that in couple's counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Professional Relationship

Your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients confidential. As much as your therapist would like to, for your confidentiality he or she will not address you in public unless you speak to him or her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Statement Regarding Ethics, Client Welfare & Safety

The Counseling Institute of Atlanta assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association and/or the American Counseling Association and/or the National Association of Social Workers and/or the American Association for Marriage and Family Therapy. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately. If the two of you are unable to resolve your concern, please contact our office manager at 404-630-1361.

The Counseling Institute of Atlanta's services are limited to counseling services including assessment, consultation, therapy, and intervention. Assessment services may include the use of questionnaires or tests which may be used to inform intervention services such as counseling and psychotherapy or to provide recommendations. Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an

increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.
Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. Your active participation and commitment are important during this process. Some people may need a few sessions and others may need more. Come to our office on time according to your scheduled appointment. If for any reason, you are not able to attend, please let us know in advance so we can use that time with another client.
Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.
The potential benefits of undergoing counseling services may include obtaining professional opinion and an increased understanding of yourself. The potential risks may include limited predictive validity of mental health assessment procedures, possible disagreement with the opinions offered, and possible emotional distress concerning the client's situation.

Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. Therefore, we've developed the following policies:
Cell phones: It is important for you to know that cell phones may not be completely secure or confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with your therapist.
Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. We realize that many people prefer to text and/or email because it is a quick way to convey information. However, please know that it is our policy to utilize these means of communication strictly for appointment confirmations (nothing that could be inferred as therapy). Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. If you do, please know that your therapist will not respond. You also need to know that we are required to keep a summary or a copy of all emails and texts as part of your clinical record that address anything related to therapy.
Facebook or Social Media It is our policy not to accept requests from any current or former clients on social networking sites such as Facebook, LinkedIn, Instagram, etc. because it may compromise your confidentiality. The Counseling Institute of Atlanta has a business Facebook page and LinkedIn. You are welcome to follow us on any of these pages. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to The Counseling Institute of Atlanta. Please refrain from making contact with us using social media messaging systems such as Facebook Messenger. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message from you.
Google, Bing, etc.: It is our policy not to search for our clients on Google or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself to your therapist as you feel appropriate. If there is content on the Internet that you would like to share with your therapist for therapeutic reasons, please print this material and bring it to your session.
Faxing Medical Records: If you authorize us (in writing) via a "Release of Information" form to send your medical records or any form of protected health information to another entity for any reason, we may need to fax that information to the authorized entity. It is our responsibility to let you know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of our fax machine. However, our fax machine is kept behind two locks in our office. And, when our fax machine needs to be replaced, we will destroy the hard drive in a manner that makes future access to information on that device inaccessible.
Recommendations to Websites or Applications (Apps): During the course of treatment, your therapist may recommend that you visit certain websites for pertinent information or self-help. She or he may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites and/or apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide and communicate to your therapist if you would like this information as adjunct to your treatment or if you prefer that your therapist does not make these recommendations.
In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that we are open to any feelings or thoughts you have about these and other modalities of communication.

In Case of an Emergency

The Counseling Institute of Atlanta is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- 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

Our Agreement to Enter into a Therapeutic Relationship

We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask your therapist.

By signing this agreement, I agree to the terms and conditions outlined herein and have had the opportunity to ask questions and/or discuss concerns.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your therapist, and you are authorizing your therapist to begin treatment with you.

______________________________ _______________
Client Name (Please Print) Date

____
Client Signature

If Applicable:

______________________________ _______________
Parent’s or Legal Guardian’s Name (Please Print) Date

____
Parent’s or Legal Guardian’s Signature

The signature of the therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

______________________________ _______________
Therapist’s Signature Date

Counseling Institute of Atlanta, Inc.

Bilingual & Multicultural Mental Health Services

NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGMENT

My signature acknowledges that I was explained and have received a copy from the Counseling Institute of Atlanta, Inc. of the Notice of Policies and Practices to Protect the Privacy of Your Health Information.
This notice details the policies that protect the privacy of my personal health information.
I consent to the use and disclosure of my protected mental health information by the Counseling Institute of Atlanta, Inc. for the purpose of providing treatment to me, obtaining payment for the mental health services provided, and/or to conduct other counseling services.
I understand that I may ask questions and discuss any concerns that I might have regarding these policies and practices with the staff of the Counseling Institute of Atlanta, Inc.

Client's Signature: ____ Date: ____________________

Client's Name: ____ Date of Birth: _____________________

Counseling Institute of Atlanta, Inc.

Bilingual & Multicultural Mental Health Services

CANCELLATION AND MISSED APPOINTMENT POLICIES

Structure and Cost of Sessions

Mental health evaluations cost $550 for a 1, 2, 3, or 4 sessions evaluation.
If your attorney recommends 5 sessions, the cost will be $600 for the evaluation. Workers compensation or other types of evaluations cost $1,000. Doing psychotherapy by telephone is not ideal, and needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed at $50 for up to 30 minutes.
The fee for each session will be due at the beginning of the session. Cash, credit cards- Visa, MasterCard, Discover, or American Express- are acceptable for payment, and we will provide you with a receipt of payment.
The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that we do not accept checks. In case you want us to mail you or your attttorney a report, there will be a $15 fee for mailing.
We do not accept insurance. Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. We will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify your therapist at least 48 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed a full session fee for your missed appointment.
You will have to pay that session at the beginning of your next appointment or call us to provide your card information. We will try to contact you two days in advance to remind your appointment; however, it is your responsibility to keep your appointments or call us to reschedule or cancel your appointment with 48 hours in advanced.
In other words, if we do not call you and you do not cancel or reschedule on time, you are still responsible for paying the missed session.

Thank you for understanding and for your cooperation. The signature below acknowledges that I understand and accept the terms and conditions of this policy.

Client's Signature: ____ Date: ____________________

Counseling Institute of Atlanta, Inc.

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CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your therapy or mental health evaluation, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document. This also applies if your case is of a legal nature.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below.

I, ____ (client's name), hereby authorize the Counseling Institute of Atlanta and the following party or parties to discuss my mental health treatment information and records obtained in the course of psychotherapy treatment or mental health evaluation, including, but not limited to, therapist's diagnosis:

(1) ____

(2) ____

(3) ____

Please, note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:
____ The parties stated above may discuss my medical and/or mental health information without limitations.
____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows: ____

Additionally, the above named parties, therapist & person(s) or entity (entities) designated under (1) or (2), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named therapist at the address of the Counseling Institute of Atlanta to be effective.

Client's Signature:____ Date: _______________________

Parent's/Legal Guardian's Signature:____ Date: ______________________

Therapist's Signature:____ Date: ______________________