



Client Information & Therapy Intake

Client's Name: First

Middle

Last

Preferred

Spouse Name: First

Middle

Last

Preferred

Address:

Telephone:

Preferred?

(cell): _____

(home): _____

(work): _____

May we leave a message for you? YES / NO

EMAIL: _____

Signature: _____ **Date:** _____

Birthdate

Age

Gender

Educational Level:

Marital Status:

Names Of Children/Other Family

DOB

Age

Relationship to Client

Occupation:

Length of Employment

(If Under 18) Parent/Guardian Information:

Emergency Contact: (Name and Contact number)

Same as client

Address _____

Phone _____

Are you currently under a physician's care for physical problems? (circle one) YES / NO

If yes, Explain? Any Medications?

Name/Telephone of Family physician:

Previous or Current Counseling: (circle one) YES / NO (if so where?)

Have you Been Referred to This Agency? (circle one) YES / NO

If so, by who?

INSURANCE INFORMATION: (self-pay clients may skip this section)

Primary Insurance Provider: _____

Group # _____

Insurance Address: _____

ID # _____

Insurance Phone: _____

If covered under the policy of a spouse, parent or legal guardian, or someone else, please tell us about them. Claims cannot be filed without complete information. Please provide a copy of the insurance card.

Insured's Name:

Date of Birth: _____

Address: **same as client**

Insured Employer Name: _____

Please describe your reason for seeking counseling?

How important are spiritual/religious issues to you? (circle one)

Not at all	Average Importance	Very Important
1	2	3

PLEASE CHECK ALL THAT APPLY & CIRCLE THE MAIN PROBLEM:

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

FAMILY HISTORY OF: (check all that apply)

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Drug/Alcohol Problems	<input type="checkbox"/>	<input type="checkbox"/>	Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Legal Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	“Nervous Breakdown”	<input type="checkbox"/>	<input type="checkbox"/>

CERTIFICATION OF INFORMATION:

I affirm that the above information is true and correct and I will inform my therapist of any information changes.

Signature: _____

Date: _____



INFORMATION, AUTHORIZATION, and CONSENT TO TREATMENT

Welcome to The Rapha House. We are very pleased that you selected our agency for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what to expect from your therapist or group leader, policies regarding confidentiality, and emergencies. 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 informed of every part of your therapeutic experience.

Background Information, Theoretical Views, and Client Participation

The Rapha House is a ministry offered by ChristChurch Presbyterian of Dalton, providing counseling in a faith-based context for individuals, couples, families, and groups. The staff consists of fully licensed counselors as well as licensed associate counselors working under the supervision of licensed counselors. The Rapha House's services are available to the community regardless of religious affiliation. You can find more information about staff members by viewing our website: <https://www.counselingatraphahouse.org>

We believe that as people become more aware and 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 longer periods of time. As a client, you are in complete control, and you may end your relationship with your therapist/group leader 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.

It is our policy to see clients who we believe have the capacity to resolve their 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 do not 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 can be of assistance to you. Your personal development is our priority. Our goal is to facilitate healing and growth, and we are committed to helping you in whatever way seems to produce maximum benefit.

In order to provide the most ethical standard of service to minors, The Rapha House Staff requires the parents or legal guardians to sign consent for counseling services. We consider it important that both parents of children are aware of services rendered and are in agreement for the child to receive counseling.

Confidentiality and Records

Your communications with your therapist will become part of a clinical record of treatment, and is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our locked therapists' offices or in a HIPAA compliant program. Additionally, your therapist will always keep everything you say to him/her completely confidential with the following exceptions:

1. You willingly sign a *Release of Information* form
2. Your therapist determines that you are a danger to yourself or to others
3. You disclose unreported information about the abuse, neglect or endangerment of a child, elderly person, or a disabled individual who may require protection
4. Your therapist is licensed at the Associate level and discusses case information with their supervisor
5. Your therapist is ordered by a judge to disclose information. In this case, your therapist's license does provide them 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.

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.

Structure and Cost of Sessions

At The Rapha House, therapist's fees may be billed to your insurance company at the contracted rate. For those not using insurance, speak to your therapist about their self-pay rate. Fees are based on a session lasting 45-50 minutes. There may be additional fees for sessions lasting longer than one hour, telephone calls lasting over five minutes, and meetings necessary for your therapist to attend as part of your treatment. If a lower fee is needed this will be determined with your counselor in the initial session. The fee or co-pay for each session will be due at the conclusion of the session. There will be a \$25 fee for any returned checks. Should the fee not be paid for three sessions, no further sessions will be scheduled until the balance is paid, unless you have discussed this issue and worked out an agreement with your counselor.

Insurance companies have various requirements to certain plans. It is your responsibility to find out your insurance company's policies. Not all of our counselors accept insurance benefits. However, if you are able to use insurance benefits with your counselor, they may agree to file insurance claims on your behalf. *Your signature on this consent serves as a consent for your counselor to release the necessary information for the insurance company to process your claim.*

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify your therapist at least 24 hours in advance. If that notice is not received, you will be financially responsible for the session you missed. Insurance companies do not reimburse for missed sessions. If you "no-show" for the appointment without calling, you will be charged your regular fee, with the exception of extreme circumstances on a case-by-case basis. Due to the high number of clients that are on the waiting list, it is our policy to terminate treatment if current clients "no show" for three sessions during the course of treatment. If this happens and your therapist has to end your treatment, you will be allowed to go back on that therapist's waiting list at the next available scheduling.

In Case of an Emergency

The Rapha House is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We are not available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and they can discuss additional resources or refer you to a therapist or clinic with 24-hour availability. Generally, your therapist will return telephone calls within 24-28 hours. If you have a mental health emergency, please access one of the following resources:

- Call Georgia Crisis & Access Line: 800-715-4225

- Call Hamilton Medical Center, 706-272-6000 or your local hospital
- Call 911
- Go to your nearest emergency department

Professional Relationship

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, 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. Dual relationship is considered unethical in the mental health profession. It can set up conflicts between the therapist's interests and the client's interests, and then the client's interests might not be put first. In order to offer all 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 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 address you in public, for your confidentiality, he or she will not address you unless you speak to them 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 summary, it is the duty of your therapist to always maintain a professional role. Please know that these guidelines are not meant to be discourteous, they are for your long-term protection.

Statement Regarding Ethics, Client Welfare and Safety

The Rapha House assures you that services will be rendered in a professional manner consistent with the American Counseling Association and/or the American Association for Marriage and Family Therapy. If you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let them know immediately. If the two of you are unable to resolve your concern, please contact the Director of The Rapha House.

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. Your therapist, and your participation in the counseling process can achieve the best possible results. 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.

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 is not sensitive unless it needs attention. Therefore, discovering the discomfort is actually considered progress. When you and your therapist are able to target your specific treatment needs and the particular methods that work best for you, help is generally on the way.

Technology Statement

In our ever-changing technological society, there are several ways we could communicate or follow each other electronically. It is of the utmost importance that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. These are our policies:

- *Cell phones, text messaging, and email* are not secure means of communication and could compromise your confidentiality. Please discuss your preferences for calls, texts, and emails. We prefer to use these methods of communication strictly for brief topics such as appointment arrangements. Please do not bring up any therapeutic content to prevent your confidentiality. You need to know that we are required to keep a copy of all communications as part of your clinical record.
- *Social media* (facebook, Instagram, pinterest, linkedin, etc) are not platforms that we use with clients because it could compromise your confidentiality. The Rapha House has a business facebook page and you are welcome to follow us on this page. Please do so only if you are comfortable with the general public being aware of the fact that your name is attached to The Rapha House. If you would like to follow us on facebook, you might consider using an alias to keep your connection with us confidential. That is entirely your decision.
- *Google, etc.*; It is our policy not to search for clients on any search engine. We respect your privacy and allow you to share information about yourself to your therapist as you feel appropriate.

TeleMental Health

TeleMental Health or telehealth is defined by the Georgia Code 135-11-.01 as a “mode of delivering services via technology-assisted media, such as but not limited to a telephone, video, internet, smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers.”

The Rapha House counselors use video conferencing platforms that are encrypted to the federal standard, are HIPAA compliant, and have signed a HIPAA Business Associate Agreement (BAA). This will keep our interaction secure and confidential. We strongly suggest you only communicate through a device that you know is safe (e.g. has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network).

There are procedures that need to be in place specific to telemental health services. These are for your safety in case of emergency.

- If you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, it may be determined that you need a higher level of care than telemental health services can provide.
- The name of an emergency contact person is required if we need to contact them on your behalf in a life-threatening emergency. Please verify with that person that they are willing and able to go to your location in the event of an emergency. *Your signature at the end of this document indicates that you understand this person will only be contacted in the event of an extreme circumstance.*
- Name: _____ Phone: _____
- You agree to provide the address where you are at the beginning of every telemental health session

- You agree to provide the nearest mental health hospital to your primary location that you prefer to go in the event of a mental health emergency. Please list this hospital and number:
- Hospital: _____ Phone: _____

If there happens to be a technological failure, the most reliable backup plan is to contact one another by telephone. Please have your phone with you. If we get disconnected from a video session, end and restart the session. If we are unable to reconnect within ten minutes, please call back.

Telemental health services come with limitations and they should not be viewed as a complete substitute for therapy in the office. It is an alternative form of therapy, and there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking, the counselor may not see the tear in your eye. Or if audio quality is lacking the counselor might not hear the crack in your voice that could easily be picked up if you were in the office.

Agreement to Enter into a Therapeutic Relationship

Your signature indicates that you have read and understood the content of this document, and you agree to the policies of your relationship with your therapist or group leader. This authorizes your therapist/group leader to begin treatment with you.

- Video Conferencing
- \$_____ per session
- Insurance (*contracted rate which may include copays/co-insurance*)
- Financial grants, (*i.e. church, employer or, PS Scholarship*)

Client/Parent/Guardian Signature: _____ Date _____

Client/Parent/Guardian Signature: _____ Date _____

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

Therapist Signature: _____ Date _____



PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides patient protections related to the electronic transmission of data (“the transaction rules”), the keeping and use of patient records (“privacy rules”), and storage and access to health care records (“security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, The Rapha House is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

The Rapha House
HIPAA Compliance Officer

Patient Name (print) _____

I have received a copy of the The Rapha House Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and that I may at any time, now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy.

Patient Signature

Date

Parent/Guardian Signature if client is a Minor or Legal Charge

Date