Client Information Form

Today's Date _____
Home Phone _____
Cell Phone _____
Work Phone _____

Client's Name_____
Address _____City _____State _____ Zip _____
E-mail_____
Age _____ Date of Birth _____

Gender:_____

Relationship Status: _____

Where would you like me to leave you messages?
❑ Home ❑ Work ❑ Cell ❑ Email ❑ None

If there is an emergency at the office and we must cancel your appointment, where should we call? ❑ Home ❑ Work ❑ Cell ❑ Email ❑ None

Employer-Self_____Occupation_____
Employer-Spouse_____Occupation_____

Why are you seeking counseling?

Are you currently in counseling elsewhere? ❑ Yes ❑ No **If yes, do not complete this form.**

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?

Name_____Relationship to Client_____
Address _____ City_____ State_____
Zip_____
E-mail_____
Age _____ Date of Birth _____Soc Sec No._____
Work Phone _____ Home Phone _____ Cell Phone _____

ABOUT YOU

Where did you attend public school?_____
Did you attend college? When, where?
_____
Any plans to further your education? _____ If so, when and what? _____

ABOUT YOUR HEALTH

Who is your doctor? _____When was the last visit? _____
Any concerns shared by the doctor?
_____
Describe any allergies you have
_____
Do you have any chronic medical concerns? _____Please list _____
Do you have a Mental Health diagnosis? If so, which one
_____
Are you under the care of a Psychiatrist? If so, whom _____
Have you been prescribed any psychotropic drugs by your Psychiatrist? ❑ Yes ❑ No
List all medications or drugs (legal or illegal) you have taken in the last year
_____
List all diseases, illnesses, important accidents and injuries, periods of loss of consciousness, convulsions/seizures, and any other medical condition you have had.
_____

Professional Disclosure Statement And Informed Consent

PLEASE INITIAL EACH ITEM:

_____ I understand that Adam Froerer, Ph.D., LMFT is a Licensed Marriage and Family Therapist in the state of Georgia.

_____ I understand that Adam Froerer, Ph.D., LMFT does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance.

_____ I understand that during the time that we work together, we will meet for approximately 45-50 minutes. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one.

_____ I also understand our contact will be limited to therapy sessions except, only in case of emergency, you may call Adam Froerer, Ph.D., LMFT at (678) 693-2232.

_____ I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the therapy relationship and that specific results are not guaranteed although benefits are expected from therapy.

_____ I understand that therapy can improve as well as upset the equilibrium in any person or family. Therapy is a personal exploration and may lead to changes in my life perspectives and decisions. These changes could be temporarily distressing.

_____ I understand that I am in control of the therapy relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with Adam Froerer, Ph.D., LMFT's services as a therapist, I have a right to let him know. If I do not feel that Adam Froerer, Ph.D., LMFT may resolve my complaint, I may file a formal complaint through contact with the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists at 478-207-2440.

_____ I understand that our paths may cross in social situations but that our therapeutic relationship comes first, along with protection of my confidentiality, and that Adam Froerer, Ph.D., LMFT does not initiate the greetings.

_____ Should I believe that a referral is needed, Adam Froerer, Ph.D., LMFT will provide some alternatives including programs and/or people who may be able to assist me.

_____ I understand that the rate for individual counseling sessions is $175.00 for a 50-minute session.

_____ I understand that the rate for couples and family counseling is $175.00 for a 50-minute session.

_____ I understand that all fees for counseling are due at the time of each session.

_____ I understand that the rate for all subsequent therapy services such as: participating in legal depositions, interactions with insurance companies, phone calls over 5 minutes, etc. will be billed at $175.00 per hour in 10-minute increments.

_____ I understand that conducting expert witness and testimonial services is not an area of interest of Adam Froerer, Ph.D., LMFT and should I subpoena Adam Froerer, Ph.D., LMFT as a factual case witness or involve him in any court-related processes, Adam Froerer, Ph.D., LMFT charges a retainer fee of $5000.00, with an additional $500.00 every hour he is involved in legal depositions, case preparation, travel, and witness time.

_____ I understand that if I do issue Adam Froerer, Ph.D, LMFT a subpoena without his approval (see above) that my subpoena will be directly turned over to his attorney and a bill will be rendered to me for immediate retainer fee payment.
_____ I understand that if a check is returned, a processing fee of $25.00 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and $25.00 processing fee. After a returned check, Adam Froerer, Ph.D., LMFT may require cash payment of future appointments.
_____ I understand that if a returned check is not cleared up in 30 days, Adam Froerer, Ph.D., LMFT will file a suit with the Gwinnett County District Attorney's Office.
_____ I understand that I am responsible for any appointments that are not canceled at least 24 hours prior to my appointment time, with the EXCEPTION OF AN EMERGENCY.
_____ I understand that if I do not cancel my appointment 24 hours ahead of time, the fee for calling to cancel on the day of my appointment is $75.00.
_____ I understand that if I do not show up for an appointment it will result in my being charged $100.00 for the full missed session.
_____ I understand that my records and all of our communications become part of the clinical record. Records are the property of Adam Froerer, Ph.D., LMFT. Adult client records are disposed of seven (7) years after the client has stopped receiving services
_____ I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

- You are a danger to yourself or someone else.
- In situations of suspected child, spouse, or elder abuse, it is the duty of the mental health provider to notify medical, legal, or other authorities.
- You disclose sexual contact with another mental health professional.
- If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
- Adam Froerer, Ph.D., LMFT is ordered by a court to disclose information.
- You direct Adam Froerer, Ph.D., LMFT in writing to release your records.
- Adam Froerer, Ph.D., LMFT is otherwise required by law to disclose information.

MENTAL STATUS INFORMATION

Have you ever attempted suicide or harmed yourself in any way? ❑ Yes ❑ No

Are you currently thinking about suicide or harming yourself in any way? ❑ Yes ❑ No

Have you had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? ❑ Yes ❑ No

Are you having any thoughts about harming anyone else in any way? ❑ Yes ❑ No

STATEMENT OF UNDERSTANDING

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge

_____

Client Signature Date

AGREEMENT FOR THERAPY

I,_____

❏ Agree to receive therapeutic services provided by Dr. Adam Froerer, Ph.D., LMFT.

❏ I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both myself and my family.
❏ Furthermore, I understand that I am expected to be an active participant in this process.
❏ I acknowledge that I have received and understand the Notice of Privacy Practices for this office.
❏ My signature below means that I understand and agree with all of the points above.

_____

Client Signature Date

HEALTH PROVIDER'S STATEMENT

I have inquired to ensure that the patient understood the above description of the limits on confidentiality.

_____

Health Provider's Signature Date

HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this office:

_____

Client signature (parent or guardian if minor patient) Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release Dr. Adam Froerer, Ph.D., LMFT to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

_____ _____

Client signature (parent or guardian if minor patient) Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.