COUNSELING ASSOCIATES OF WEST CENTRAL GEORGIA

113 Bascom Court, Suite C
Columbus, Georgia 31909
Office: (706) 569-7254
Fax: (706) 569-9212
CounselingAssociates@prodigy.net

For Office Use Only:
Date of Initial Visit _____
Acct # _____
Clinician _____
Scanned _____

# NEW CLIENT INFORMATION

Please complete this entire form. Much of this information is necessary in order to file EAP, and/or insurance.

Patient/Client:
Name _____ Date of Birth (DOB) _____
Age _____ Sex _____ Social Security # _____ Race _____
Address _____ City _____ State _____ Zip _____
Email Address: _____
Home Phone _____ Work Phone _____ Cell phone/pager # _____
Occupation _____ Employer _____ How Long _____
Religion _____ Local Affiliation _____
Education Completed _____ Name of School Currently Attending (if applicable) _____

Spouse (if applicable):
Name _____ DOB _____ Work Phone _____
Social Security # _____ Education _____ Religion _____
Occupation _____ Employer _____ How Long _____

Marital Status:
Single __ Live-In __ Married __ Divorced __ Widowed __ Date of Marriage or Re-marriage _____

Children's Name(s) and Age(s):
_____
_____

Client Family History:
Mother's Name and Age_____
Education/Occupation_____ Number of times married_____
Father's Name and Age_____
Education/Occupation_____ Number of times married_____
Are your parents...
__ Separated? If yes, please indicate your age at the time. _____
__ Divorced? If yes, please indicate your age at the time. _____
__ Deceased? If yes, please indicate your age at the time. _____
__ Remarried? If yes, please indicate your age at the time and your step-parent's name(s).
Birth Order: I was born the _____ of _____children.

Mental Health Information:

Please tell us what you are experiencing and/or what has happened to cause you to seek counseling. (Use back of page if needed.)

_____

_____

_____

_____

_____

_____

Please tell us about any previous mental health care you've received and dates _____

_____

_____

_____

General Health Information:

Are you presently under the care of a physician? _____ Yes _____ No

Name of physician _____

Physician's Address _____

Physician's Phone Number _____

Date of last physical examination _____

Dates of surgical/invasive procedures _____

_____

_____

Amount of alcohol consumed daily _____

List medication(s) taken regularly _____

_____

_____

Do you exercise _____ Yes _____ No If yes, how often _____

Other Information:

Emergency Contact:

Name _____ Relation _____

Address _____

Work Phone _____ Home Phone _____

Financial and Insurance Information:

If the person responsible for payment is the same as the client, write SAME and go to Primary Insurance section.

Name of Person Responsible for Bill _____

Relationship to Client _____ Social Security # _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Employer _____Work Phone _____

Home Phone _____

Primary Insurance (This will be the insurance company that we file the claim with first.):

Name of Policy Holder _____ Policy # of Insured _____

Name of Insurance Company _____

Insured's Date of Birth _____ Insured's Employer _____

Insurance Authorization # (if applicable) _____

Secondary Insurance (if applicable):

Name of Policy Holder _____ Policy # of Insured _____

Name of Insurance Company _____

Insured's Date of Birth _____ Insured's Employer _____

Insurance Authorization # (if applicable) _____

In order to file your insurance, we must have a copy of your insurance card.

Authorization to Release Information and Assignment of Benefits

I hereby authorize Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE, or any member of its staff, to release to my insurance company or companies any information acquired in the course of my examination or treatment.

You are hereby authorized to pay to Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE, Inc., Basic Benefits and/or Major Medical Benefits for medical expenses, or to include their name on the check payable to me for medical expenses otherwise payable to me for treatment.

In making this assignment I understand and agree any unpaid balance not covered by this policy will be paid by me. I understand that filing of insurance does not guarantee payment.

_____ _____

Client Name (Printed) Witness Name (Printed)

_____ _____

Client Signature and Date
(or Parent's Signature if Client is a minor)

Witness Signature and Date

This form must be signed in order for Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE to file charges with your insurance company.

COUNSELING ASSOCIATES OF WEST CENTRAL GEORGIA

# FINANCIAL POLICY AGREEMENT

The following guidelines have been established in order to clarify any questions:

1. If you have health insurance, we will be glad to assist you in determining coverage, filing claims and seeking reimbursement. Please see our Business Office regarding any insurance that we will be filing on your behalf. *We cannot guarantee insurance reimbursement.* All fees charged are the direct responsibility of the client.
2. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is your responsibility to follow up with your insurance company to make sure they pay your claims.
3. If your insurance coverage for mental health services requires pre-authorization, you must call for authorization. If you have not called, please call for authorization immediately. Your insurance company will not pay for services that have not been authorized.
4. If your insurance company does not pay within 90 days, the unpaid balance is due from you.
5. Payments for co-pays and deductibles are due at the time service is rendered. Payments may be made by cash, check, debit cards, or credit cards. All returned checks are forwarded for collection. Collection agency adds an additional fee for collection.
6. OUR POLICY IS TO BILL FULL FEE ($100.00) FOR ANY APPOINTMENT CANCELED WITHOUT 24-HOUR ADVANCED NOTICE FOR ANY REASON. The payment must be made prior to the next appointment.
7. Accounts that become more than 90 days past due may be forwarded to our collection agency.
8. While Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE understands that some blended family situations are complicated; we cannot and will not become entangled with various arrangements set forth in Divorce Decrees and the like. Therefore, payment for any and all services rendered will be expected from the guardian that escorts the patient to his/her appointments.
9. Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE will charge for any professional consultation time related but not limited to legal dispositions, appearance, etc.

FINANCIAL AGREEMENT

I understand the above financial arrangements. I also understand I will receive a statement each month if there is a balance due from me. I agree that statements are correct unless questioned within 30 days in writing or telephone contact with Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE Business Office.

_____ _____

Guarantor Name (Printed) Witness Name (Printed)

_____ _____

Guarantor Signature and Date Witness Signature and Date

COUNSELING ASSOCIATES OF WEST CENTRAL GEORGIA

# COUNSELING, CONFIDENTIALITY AND PRIVACY PRACTI CE AGREEMENT

I am aware that the practice of counseling is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatment by Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE's staff members.

I agree to collaborate with my therapist and other appropriate professional staff members of Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE for the purpose of assessment and evaluation of my current situation and to work together to identify appropriate goals and methods of achieving them.

I understand that over the course of therapy, whatever assessments, tests or other clinical care that is recommended will be fully explained to me and that I have the option to accept or reject such care.

I understand that Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care. I UNDERSTAND THAT CELL PHONE CALLS, TEXT MESSAGES, AND REGULAR INTERNET E-MAILS ARE NOT HIPPA COMPLIANT AND WAVE MY RIGHTS AS A CLIENT IF I CHOSE TO USE THESE TYPES OF COMMUNICATIONS. I MUST GIVE NOTICE TO IF I DO NOT WISH FOR THESE FORMS OF COMMUNICATION TO BE USED.

I have read the above and give my consent to the counseling process. I have also read and understand the Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE's statement regarding the limits of confidentiality.

I have had an opportunity to review Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE's Notice of Privacy Practices.
I have had an opportunity to ask questions to seek any clarification I needed about these important materials.

_____
Client's Name (Please Print)

_____
Client's Signature and Date
(or Parent's Signature if Client is a minor)

_____
Witness Signature and Date

COUNSELING ASSOCIATES OF WEST CENTRAL GEORGIA

NOTICE OF
COUNSELING ASSOCIATES OF WEST CENTRAL GEORGIA /
C. JEFFREY BROGDON, M.S., LPC, NCC, CCCE
PRIVACY PRACTICES
For Your Records - *Client Copy*

This notice tells you how we make use of your health information at our Center, how we might disclose your health information to others, and how you can get access to the same information.

Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have a legal responsibility under the laws of the United States and the state of Georgia to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.

This notice takes effect on April 14, 2003 and will be in effect until we replace it. We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE, Inc. These changes could also affect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice.

When you are finished reading this notice, you may request a copy of it at no charge to you. If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you. If you have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no charge to you.

Here are some examples of how we use and disclose information about your health information.

We may use or disclose your health information…

1. To your physician or other healthcare provider who is also treating you with your written authorization.
2. To Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE staff involved in your treatment program.
3. To any person required by federal, state or local laws to have lawful access to your treatment program.
4. To receive payment from a third-party payer for services we provide for you.
5. To anyone you give us written authorization to have your health information, for any reason you want.
6. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only affect your health information from that point on.

7. To a family member, a person responsible for your care or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at the time. In so doing, we will only use or disclose the aspects of your health information that are necessary to respond to the emergency.

8. To appropriate authorities under Georgia Law in the following circumstances: Imminent Danger to you or others, Child Abuse or under Court Order.

9. To help us carry out health care operations such as appointment reminders, insurance items and calls pertaining to your clinical care.

We will not use your health information in any of our Center's marketing, development, public relations or related activities without your written authorization.

We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

As a client of Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE, you have these important rights:

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.

B. You can ask us for photocopies of the information in part "A" above.

C. We will charge you $0.10 per page for making these photocopies.

D. You have a right to a copy of this notice at no charge.

E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if your primary language is not spoken at this Center, and we are treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.

F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those that, in our professional judgment, constitute an emergency.

G. You can make a written request that we amend the information in part "A" above.

H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.

I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.

J. You may make a written request that we provide you with a list of those occasions where we, or our business associates disclosed your health information for purposes other than treatment, payment, or our Center's operations. This can go back as far as six years, but not before April 14, 2003.

K. If you request the accounting in "J" above more than once in a 12 month period we may charge you a fee based on our actual costs of tabulating these disclosures.

L. If you believe, we have violated any of your privacy rights or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person: Sharron Brogdon, Office Administrator, Counseling Associates of West Central Georgia; 3228 University Avenue, Bentwood Office Park, Suite 109, Columbus, Georgia 31909. Phone (706) 569-7254 Fax (706) 569-9212

M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

COUNSELING ASSOCIATES OF WEST CENTRAL GEORGIA /
C. JEFFREY BROGDON, M.S., LPC, NCC, CCCE
CONFIDENTIALITY STATEMENT

We are glad you have chosen Counseling Associates of West Central Georgia / C. Jeffrey Brogdon, M.S., LPC, NCC, CCCE. Below is some information written for you to clarify confidentiality in the counseling process.

CONFIDENTIALITY

We commit to keep confidential what you say in the counseling process. The following are the only exceptions:

1. Supervision/Case consultation. A part of our commitment to providing quality care for you is to regularly consult with other professionals on staff. Your identity is kept confidential during these consultations. From time to time, we may also audio or videotape your sessions, but only after receiving your written permission. The taping would be used for our professional consultations and in counselor training.

2. Requirements by law. The records from your counseling are confidential and cannot be released to anyone without your written consent except under the following conditions provided by the law:

   • Imminent Danger – The law states that if we judge you to be a danger to yourself or others, we are required to take action to prevent harm from occurring to you or others.
   • Child Abuse – We are required by law to report all cases of actual or suspected physical, emotional, or sexual abuse or neglect of children to the Department of Family and Children Services.
   • Court ordered

We hope this information is helpful to you. Please feel free to ask questions.

BILLING AND CORRESPONDENCE ADDRESS:
Counseling Associates of West Central Georgia
Colvin Jeffrey Brogdon, M.S., LPC, NCC, CCCE
3228 University Avenue
Bentwood Office Park, Suite 109
Columbus, Georgia 31907
(706) 569-7254

*Client Copy*