ACTIVE SOLUTIONS COUNSELING, LLC
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OFFICE POLICIES, PROCEDURES AND SERVICES AGREEMENT

WELCOME…AND WHAT TO EXPECT

Welcome to my practice. I am looking forward to our sessions together. My approach is active and supportive, using strengths and working as a team.

In your first or second session of therapy, we will create a treatment plan together. This plan will be based on questions I ask you about your history, information you tell me about the problems which made you decide to come for therapy, and the results of some basic screening questionnaires you fill out.

From all of this data, we will agree on goals for therapy, a general time frame for achieving these goals, and the steps for moving from where you currently are to where you want to be psychologically.

Throughout the sessions we have, I will give you homework assignments to complete between sessions. Homework will often include reading, writing, and practicing things we've talked about during the session. It is very important to your progress that you complete the homework between sessions.

At each session we will evaluate how you feel you are doing toward reaching your goals, and we may modify your treatment plan if necessary. When we feel you have accomplished what you wanted, we will stop our sessions, with the understanding that if you need to come back for additional work in other areas in the future that you may call to schedule.

WHAT IS A LICENSED PROFESSIONAL COUNSELOR?

A Licensed Professional Counselor is a specialist trained in evaluating, diagnosing and treating emotional and behavioral problems. Counselors have a master's degree and typically spend over six years in college.

An internship is completed during graduate school and supervision is provided from experienced clinicians before a counselor can complete the masters program. Counselors are licensed in the state where they practice and must pass a standardized written exam administered by the state. A counselor must also work and obtain supervision for another three years before becoming a licensed professional counselor.

Counselors are subject to a strict code of professional ethics, must complete continuing education classes and are accountable for demonstration of ongoing clinical competence.

WHAT IS A CERTIFIED ADVANCED ALCOHOL AND DRUG COUNSELOR?

A Certified Advanced Alcohol and Drug Counselor is a specialist in the area of substance abuse and addiction. A master's degree is required in the field of counseling in addition to years of substance abuse

experience and education. A standardized written exam and oral examination must be passed before becoming certified.

WHAT IS A CERTIFIED CLINICAL TRAUMA PROFESSIONAL?

A Certified Clinical Trauma Professional is a specialist in the area of trauma. A master's degree is required in addition to additional training and experience. A test must be passed before becoming certified.

THERAPY

Psychotherapy, in general statements, varies depending on the personalities and skills of the counselor and patient. Each particular problem you are experiencing and hope to discuss may be addressed using different methods. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Frequency of visits will be addressed in the individual session. As you progress, the frequency of visits may change. If you want to decrease the frequency of appointments or feel ready to terminate therapy, we can discuss accordingly.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. 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. Typically, the more invested you are in therapy, the better the outcome.

COUNSELOR – CLIENT SERVICES AGREEMENT

This section contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which follows these Office Policies and is included as part of this Agreement, explains HIPAA and it application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is important that you read them carefully. We can discuss any questions you have about the procedures. When you sign the signature page of the intake form, your signature will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

LIMITS ON CONFIDENTIALITY

Our sessions are confidential and in most cases, I can only release information about your treatment to others if you sign a written authorization form. There are other situations that require only written, advance consent. Your signature on this Agreement provides consent for those activities as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called Protected Health Information, PHI).
- Disclosures by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions and will release information without your written authorization or consent. These situations are unusual in my practice and are follows:

- You tell me of a current situation involving the welfare of a child, disabled adult or a senior, in which I am required by law to report suspected abuse or neglect. Once a report has been filed, I may be required to provide additional information.
- You report intentions to harm someone;
- You report intentions of harming yourself;
- I receive a court order from a judge to release information. I will take action to object but ultimately, I may be required to release information.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

The Privacy Policy which follows also outlines additional information regarding confidentiality of your protected health information.

This information should be helpful in informing you, however if you have any questions about confidentiality, please ask.

PROFESSIONAL RECORDS

The standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of $.50 cents per page (and for certain other expenses like postage). If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

BILLING AND PAYMENTS

You are expected to pay for the session at the beginning of the hour. If you have insurance I take, the insurance company may pay for part of this fee. If I take your insurance, I will file the insurance for you, but you are responsible for assuring that the insurance company pays their part of your bill. I am paid different rates by different insurance companies. If you have questions about any charges or fees, please feel free to discuss these with me. The parts of my fee not covered by insurance (the co-pay and/or coinsurance and deductible) are your responsibility, and I will expect you to pay them at the time of the session. **You are required to know how much your part of the fee will be, and to be sure that your sessions are authorized ahead of time by the insurance company or the managed care company administering the benefits for the insurance company.** This is usually done by calling the number for mental health services on your insurance card. Please remember that when a managed care company authorizes sessions, the paperwork contains a disclaimer that even though they are authorizing the service, they cannot guarantee payment. This is the responsibility of you and your insurance company. In the event you do not know your co-pay or co-insurance, you will be responsible for the full amount at the time of service and can request reimbursement from your insurance company.

If I do not accept your insurance, you may request a bill which you may submit to your insurance company. Some insurance companies will reimburse you with the "out of network" benefit. It is your responsibility to find out if your insurance will pay for an out of network therapist. This is usually accomplished by calling the number for mental health services or behavioral health services on the back of your insurance card.

Your therapy appointment time is reserved only for you. This is different from other medical offices, where more than one person may be scheduled at the same time. If you run late to an appointment, it will still end at the scheduled time, because someone has a scheduled appointment right after yours. **If you**

miss an appointment FOR ANY REASON, you will be charged the full fee of $125 for the session if you do not call at least 24 hours in advance of your appointment to cancel the appointment. Your insurance will not reimburse you for a missed appointment fee. If you need to cancel an appointment, call my number and leave a voice mail.

I accept cash, checks and money orders as payment for your session. Credit cards are **not** accepted. In the event that you have a check returned to me for non-payment of funds, you will be expected to pay for the associated costs I have. These charges will include a returned check charge and any bank charges that I incur. I may also ask you to pay by cash or money order in the future.

EMERGENCY AND AFTER HOUR CALLS

I schedule appointments Monday through Friday. My cell phone number is available to you and if I do not answer, I encourage you to leave a message. I check my messages daily and will return calls as soon as possible. If you call after 6:00pm, I will return your call if necessary but will most likely call the following day. If you call on the weekend or when the office is closed, I screen messages and if you do not have an emergency, your call will be returned on the next business day. Please note, even though I have a cell phone I am not always available when the office is closed. There can be times when I do not check my phone for hours or I may not have coverage. **If you have an emergency,** and I do not return your call within a few minutes, please contact the emergency room of the hospital covered by your insurance company or call 911. In addition to 911, you can call the following emergency contact numbers:

Ridgeview Institute – 770-434-4567
Peachford Hospital – 770-454-5589
Behavioral Health Link (24 hour crisis line) – 1-800-715-4225
Lifeline (National Crisis Line) – 1-800-273-8255.

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 me that I maintain your confidentiality, respect your boundaries, and ascertain that your relationship with me remains therapeutic and professional. Therefore, I'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, I realize that most people have and utilize a cell phone. I will use a cell phone to contact you. If this is a problem, please feel free to discuss this with me.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. I 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 my policy to utilize these means of communication mainly for appointment confirmations.** Please know that if you bring up any therapeutic issues, your confidentiality may be comprised as I do not use an encrypted mail or text system. You also need to know that I keep a summary or copy of all emails and texts as part of your clinical record that address anything related to therapy.

Google, Bing, etc.: It is my policy not to search for my clients on Google or any other search engine. I respect your privacy and make it a policy to allow you to share information about yourself with me as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material and bring it to your session.

Faxing Medical Records: If you authorize me (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, I may need to fax that information to the authorized entity. It is my 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 my fax machine. However, my fax machine is kept behind two locks in my office. And, when my fax machine needs to be replaced, I 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 our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I 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/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 me if you would like this information as adjunct to your treatment or if you prefer that I do 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 I am open to any feelings or thoughts you have about these and other modalities of communication.

Notice of Privacy Practices
Chrischel S. Ramsey, LPC, CAADC, CCTP

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY ME AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is effective April 14, 2003. It is provided to you pursuant to provisions of the Health Insurance Portability and Accountability Act of 1996 and related federal regulations. If you have questions about this Notice please contact me.

Both federal and state laws establish strict requirements for most programs regarding the disclosure of confidential information, and I must comply with those laws. For situations where stricter disclosure requirements do not apply, this Notice of Privacy Practices describes how I may use and disclose your protected health information for treatment, payment, health care operations and for certain other purposes. This notice also describes your rights to access and control your protected health information, and provides information about your right to make a complaint if you believe I have improperly used or disclosed your "protected health information." Protected health information is information that may personally identify you and relates to your past, present or future physical or mental health or condition and related health care services. I am required to abide by the terms of this Notice of Privacy Practices, and may change the terms of this notice, at any time. A new notice will be effective for all protected health information that I maintain at the time of issuance. Any changes in this notice will made available to you.

1. Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by me and others involved in your care and treatment for the purpose of providing health care services to you, and to assist in obtaining payment of your health care bills.

a. Treatment: Your protected health information may be used to provide, coordinate, or manage your health care and any related services, including coordination of your health care with a third party that has your permission to have access to your protected health information, such as, for example, a health care professional who may be treating you, or to another health care provider such as a specialist or laboratory.

b. Payment: Your protected health information may be used to obtain payment for your health care services. For example, this may include activities that a health insurance plan requires before it approves or pays for health care services such as: making a determination of eligibility or coverage, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

c. Health Care Operations: I may use or disclose your protected health information to support my business activities, including, for example, but not limited to, quality assessment activities, employee review activities, training, licensing, and other business activities. Your protected health information may be used to contact you about appointments or for other operational reasons. Your protected health information may be shared with third party "business associates" who perform various activities that assist us in the provision of your services.

2. Other Permitted or Required Uses and Disclosures with Your Authorization or Opportunity to Object

Other uses and disclosures of your protected health information will be made only with your written authorization, which you may revoke at any time, except as permitted or required by law as described below. Generally, if there is protected health information which identifies you as a person who has applied for or received substance abuse services, that information will not be disclosed without your consent unless the law allows or requires such a disclosure. I may use and disclose your protected health information when you authorize in writing such use or disclosure of all or part of your protected health information. If you are hospitalized, I may use and disclose certain protected health information to your

representative, as that term is defined in the Georgia Mental Health Code, upon your admission or discharge; you may be given a chance to object to certain other disclosures to your representative.

3. Permitted or Required Uses and Disclosures without Your Authorization or Opportunity to Object

I may use or disclose your protected health information without your authorization for continuity of your care or for your treatment in an emergency or when clinically required; when required to do so by law; for public health purposes; to a person who may be at risk of contracting a communicable disease; to a health oversight agency; to an authority authorized to receive reports of abuse or neglect; in certain legal proceedings; and for certain law enforcement purposes. Protected health information may also be disclosed without your authorization to a coroner or medical examiner, and to the legal representative of your estate.

4. Required Uses and Disclosures: Under the law, I must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine my compliance with the requirements of the Privacy Rule at 45 CFR Sections 164.500 et. seq.

5. Your Rights The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

a. You have the right to inspect and copy your protected health information. You may inspect and obtain a copy of protected health information about you for as long as I maintain the protected health information. This information includes medical and billing records and other records I use for making medical and other decisions about you. A reasonable, cost-based fee for copying, postage and labor expense may apply. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.

b. You have the right to request restriction of your protected health information. You may ask me not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations, and not to disclose protected health information to family members or friends who may be involved in your care. Such a request must state the specific restriction requested and to whom you want the restriction to apply. I am not required to agree to a restriction you request, and if I believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, except as required by law. If I do agree to the requested restriction, I may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

c. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. Upon written request to a person listed in section 6 below, I will accommodate reasonable requests for alternative means for the communication of confidential information, but may condition this accommodation upon your provision of an alternative address or other method of contact. I will not request an explanation from you as to the basis for the request.

d. You may have the right to request amendment of your protected health information. If I created your protected health information, you may request an amendment of that information for as long as it is maintained by me. I may deny your request for an amendment, and if I do, I will provide information as to any further rights you may have with respect to such denial. Please contact one of the persons listed in section 6 below if you have questions about amending your medical information.

e. You have the right to receive an accounting of certain disclosures I have made of your protected health information. This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, excluding any disclosures I made to you, to family members or friends involved in your care, or for national security, intelligence or notification purposes. You have the right to receive legally specified information regarding disclosures occurring after April 14, 2003, subject to certain exceptions, restrictions and limitations.

f. You have the right to obtain a paper copy of this notice from the Department, upon request.

6. Complaints You may complain to me and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing and I will not retaliate in any way. You must state the basis for your complaint.
Please sign a copy of this Notice of Privacy Practices for my records.

CLIENT RIGHTS AND RESPONSIBILITIES

Active Solutions Counseling, LLC supports the philosophy of client-centered care with the responsibility for the treatment being shared by the clients. Therefore, we subscribe to the following:

1. All clients' fundamental, human, civil, constitutional and statutory rights are supported and protected.
2. All clients shall have access to treatment without discrimination for any reason including race, religion, sex, ethnicity, age, handicap, or cultural background.
3. All clients have the right to receive care that is considerate, respectful and professional.
4. All clients have the right to participate in the development of their treatment plan.
5. All clients have the right to a written treatment plan of care regularly reviewed by competent and professional staff in an environment that protects the client's rights, freedom, and privacy.
6. All clients have the right to sufficient information to provide informed consent prior to the start of any type of treatment, including the specific nature and duration of the treatment as well as risks, side effects and benefits of treatment.
7. All clients have the right to be fully informed of all services available to them. The charges for those services are available to clients as well as the right to examine and review bills for treatment, regardless of payment source.
8. All clients have the right to obtain from the treatment staff complete current information regarding their diagnosis in terms they can fully understand.
9. All clients have the right to refuse treatment if, after an explanation of the consequences, they do not believe the treatment to be in their best interests. All clients need to be fully advised of the risk and potential consequences of such refusal.
10. All clients have the right to protect their records regarding treatment from inspection in accordance with local, state and federal law.
11. All clients have the right to privacy regarding their treatment program and to confidential communication in consultations, examinations, and case discussions involving their case. All clients have the right to expect that all communications and records pertaining to their case will be treated as confidential and in accordance with legal statutes and professional ethics.
12. All clients have the right to be fully informed of their rights while in treatment and will receive a copy of these rights. Signed documentation as part of the Consent for Services is filed in their medical record.
13. Clients have the right to review their medical record unless such review is determined to be detrimental to their well being. Clients may make their request verbally or in writing to staff who will approve or disapprove the request based on his/her clinical judgment. Should the request be disapproved, the client may appeal, in writing.
14. Clients have a right to receive a copy of Privacy Practices.
15. Clients have a right to request amendment to information he/she believes is inaccurate or incomplete in their medical record.
16. Clients have the right to request restrictions on communications.
17. Clients have the right to request confidential communications.
18. Clients have the right to an accounting of disclosures made of their protected health information.
19. All clients may have a copy of all consent forms, releases and other documents signed while in treatment. Copying costs are the responsibility of the client.
20. All clients have the right to voice opinions, recommendations and grievances in relation to policies and services offered by the facility, without fear of restraint, interference, coercion, discrimination or reprisal. Clients have the right to expect to receive responses via a procedure of due process.

CLIENT RESPONSIBILITIES

Clients of Active Solutions Counseling, LLC have responsibilities. These responsibilities are listed below.

1. All clients have the responsibility to participate with staff in the planning of their treatment.
2. All clients have the responsibility to be honest about matters that relate to their treatment.
3. All clients have the responsibility to be respectful of the rights and dignity of other clients, as well as staff.
4. All clients have the responsibility to respect the confidentiality and privacy of others in treatment.
5. All clients, upon decision to participate, have the responsibility to support and respect the program at the facility by participating to the best of their ability and by being on time for scheduled activities.
6. All clients have the responsibility to learn and comply with the rules of the program.
7. All clients have the responsibility to meet whatever financial obligations may be incurred as it relates to their treatment.
8. All clients have the responsibility to advise the provider of services of any changes in the client's condition or any events that affect the client's service needs.
9. All clients should understand that the following may be grounds for immediate temporary suspension from treatment, as determined appropriate by staff:
    a. Possession of any form of alcohol or drugs on the grounds,
    b. Sexual intimacy on the job/or grounds,
    c. Physical violence
    d. Gambling
    e. Leaving the grounds unauthorized
    f. Possession of a weapon while on premises,
    g. Failure to comply with client responsibilities.
10. Active Solutions Counseling, LLC has a denial of care policy which may be necessary to invoke based on pre-established criteria. This criteria may include but is not limited to:
    a. Lack of cooperation with treatment as evidenced by persistent medication non-compliance, failure to follow through/participate in lab/urine drug testing, or provided consultations.
    b. Refusal to participate in the recommendations mutually agreed to on the Plan of Care.
    c. Refusal to permit needed and essential collaboration between external care providers.
    d. Flagrant or repetitive program rule violations.

Denial of care at one point in time does not preclude a client's access to care at a future time.

After you have reviewed your Rights and Responsibilities, if you have questions or do not understand your rights please contact Chrischel S. Ramsey, LPC, CAADC, CCTP.

I have read and received copies of the Office Policies and Procedures, Emergency procedures, Notice of Privacy Practices, Technology Statement and Client Rights and Responsibilities on the date indicated below.

_____ _____

Signature of Individual or Legally Authorized Person Date

_____ _____

Witness Date

ACTIVE SOLUTIONS COUNSELING, LLC
CHRISCHEL S. RAMSEY, LPC, CAADC, CCTP
Insurance Information

Client Information (The client is the person who was authorized for counseling)

Client Name:_____ Male Female Birthdate:_____

Marital Status: Single Married Life Partner Divorced Widowed Age:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone #:_____ Work#:_____ Cell#:_____

Employer or School:_____ Position or Grade Level:_____

Primary Card Holder (The insured is the primary card holder):

Primary Card Holder Name: _____ Birthdate:_____

Male Female Relationship to client:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone #:_____ Work#:_____ Cell#:_____

Employer:_____ Position:_____

Insurance:_____ Managed Care Company:_____

Benefit & Claims Phone #_____Pre-Authorizations Phone#:_____

ID#:_____ Policy/Group #:_____ Plan#:_____

Secondary Insurance Secondary Health Insurance Plan Name:_____

ID#:_____ Policy/Group#:_____ Plan#:_____

Benefit & Claims Phone #_____ Pre-Authorizations Phone#_____

For Office Use Only Date Verified:_____ Effective Dates:_____

Pre-auth needed? Y N Pt resp subject to deductible? Y N Ded $_____Ins Pays_____$ %

Pt Pays _____$ % Payor ID #_____

Agreement to Enter Into a Therapeutic Relationship

If you have any questions about any part of this document please ask. Your initials and signature indicate that you agree to the policies outlined in this document.

POLICIES, SERVIES AGREEMENT AND HIPAA

Initial_____ I have been given, have read, and agree to follow the office policies, procedures, services agreement, and the HIPAA Notice regarding Protected Health Information.

GUARANTY OF PAYMENT

Initial_____ In consideration of counseling services extended to the undersigned insured (or dependent), I/we guarantee payment in full to Chrischel S. Ramsey, LPC, CAADC, CCTP for the amount due. I/we understand that payment (checks, cash or money order) is due prior to the session. In the event this account is collected by law or through an attorney at law, the undersigned agrees to pay all reasonable costs of collection. I/We understand that the debt incurred cannot be removed by the declaration of bankruptcy.

AUTHORIZATION TO RELEASE INFORMATION

Initial_____ I/We authorize Chrischel S. Ramsey, LPC, CAADC, CCTP to file with my insurance carrier(s) for any benefits due under that policy for these services and authorize the release to that insurance carrier any information required for the completion of that claim. I/We authorize Chrischel S. Ramsey, LPC, CAADC, CCTP to coordinate my treatment with the managed care company that authorizes the services provided and to provide them with the information they required to determine my eligibility for these services.

ASSIGNMENT OF BENEFITS

Initial_____ I assign to Chrischel S. Ramsey, LPC, CAADC, CCTP any benefits due me by any third party carrier for services rendered to the undersigned insured (or dependent), and do authorize and instruct such third parties to make payment of any benefits directly to Chrischel S. Ramsey, LPC, CAADC, CCTP. I understand that the check for any benefits due and a copy of applicable benefits summary form will be mailed directly to Chrischel S. Ramsey, LPC, CAADC, CCTP. I further agree that this assignment shall not be revoked without the consent of Chrischel S. Ramsey.

MISSED APPOINTMENTS

Initial_____ I understand that I will be charged a penalty fee equivalent to Chrischel Ramsey's full session rate of $125 for an appointment not kept or not cancelled or changed with at least 24 hours notice. I also understand that this charge is not reimbursable by a third party payor.

ACKNOWLEDGEMENT OF LIMITS OF CONFIDENTIALITY INHERENT TO TECHOLOGY SERVICES

Initial_____ I have read the technology statement and understand that I will be communicating by cell phone, text and email. I acknowledge the confidentiality limitations inherent to these modes of information exchange and give permission to my therapist to communicate with me in this manner.

IN CASE OF EMERGENCY

Initial_____ I understand that in the event of an emergency, I can call 911 or go to the hospital covered by my insurance company. I have received the emergency contact names and numbers in this paperwork.

STATEMENT OF UNDERSTANDING

Initial_____ I give my consent to treatment voluntarily.

_____ _____

Client signature Date

_____ _____

Therapist Signature Date

ACTIVE SOLUTIONS COUNSELING, LLC
CHRISCHEL S. RAMSEY, LPC, CAADC, CCTP
Phone: 678-591-3124
Fax: 770-704-9743
Email: chrischelramsey@yahoo.com
707 Whitlock Avenue, Bldg C, Suite 28
Marietta, Georgia 30064

In preparation for your counseling appointment, it will be important for you to know your behavioral health benefits. Contact your insurance company and use the following questions as a guide. Make sure to call the Behavioral Health/Substance Abuse Services or Mental Health Services phone number on the back of your card. In the event that you do not know your co-pay or co-insurance, you will be responsible for the full amount of the session and can request reimbursement from your insurance company.

1. Are my benefits based on the calendar year? Yes No If no, what month does it start? _____

2. Do I need pre-authorization for "outpatient, in office" individual or couples counseling? Yes No

   If yes, what do I need to do? _____

3. Are my visits subject to the deductible? Yes No If yes, what is my deductible? _____

   How much as been applied to my deductible? _____

4. What is my co-pay and/or co-insurance? _____

5. How many visits am I allowed per benefit year? _____

6. Are there exclusions for pre-existing conditions? _____

   Will my past counseling, therapy or treatment affect current coverage? _____

Active Solutions Counseling, LLC
Chrischel S. Ramsey, LPC, CAADC, CCTP
(678) 591-3124
707 Whitlock Avenue, Building C, Suite 28
Marietta, Georgia 30064

Client Information

Name:_____Date:_____

Address:_____City: _____Zip:_____

Home phone #:_____ May I call you at home?_____

Cell Phone #:_____ May I call your cell phone?_____

Date of Birth:_____ Age:_____

Employer Name:_____Position: _____

Employer Address:_____

Work phone #:_____ May I call you at work?_____

Relationship status: Married Single Life Partner Divorced
Separated Widowed Involved Dating

Do you have a guardian?_____ If so, please list name and phone number:_____

_____

Emergency Contacts:
Please indicate who should be contacted in case of an emergency.
Completion of this section indicates permission to contact these people should an emergency arise.

Name:	Relationship:	Phone #:

Briefly describe what brings you in for counseling:

How is this impacting your ability to function?

Have you sought counseling before? If so, complete the following:

Therapist's Name	Dates of Service	Issues Addressed	Helpful?
			Yes No
			Yes No
			Yes No

Please circle any of the following that apply to you presently or in the recent past:

Headaches	Dizziness	Stomach Trouble	Visual Trouble
Insomnia	Trouble relaxing	Weakness	Tension
Rapid Heart Rate	Difficulty Breathing	Intestinal Trouble	Hearing Noises
Change in Appetite	Tiredness	Pain	Hearing Voices
Seeing Things	Eating Problems	Excessive sleeping	Nightmares
Increased Energy	Weight loss	Tearfulness	Panic Attacks
Decreased Energy	Weight gain	Body Image Concerns	Impulsive Behavior

Stress	Nervousness	Anxiety	Panic	Crying
Unhappiness	Depression	Guilt	Apathy	Loss of ambition
Grief	Hopelessness	Loneliness	Shyness	Fears
Anger	Feeling worthless	Aggression	Irritability	Feeling Inferior

Racing Thoughts	Unwanted Thoughts	Difficulty Making Decisions
Concentration Problems	Memory Problems	Homicidal Thoughts
Paranoid Thoughts	Obsessive Thoughts	Suicidal Thoughts

Communication Problems	Recent Death	Spiritual Problems	Social/Friend Problems
Marital Problems	Job Problems	Isolating from others	Educational Problems
Family Problems	Housing Problems	Financial Problems	Health Care Issues
Legal problems			

Suicide Attempts Violent Behavior/Fights Injuring Self Reckless behavior

Other:_____

Have you seen a psychiatrist or has a doctor prescribed psychotropic medications? (anti-depressants, anti-anxiety, anti-psychotic, etc.)

Doctor's Name	Dates of Service	Medication	Reason Medication Prescribed	Helpful?
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Treatment History

Have you ever been treated by a hospital for depression, anxiety, substance use, substance withdrawal, etc. Please list any inpatient admissions, intensive outpatient programs or full day programs.

Hospital	Dates of Service	Reason admitted	Compliant with discharge recommendations?	Was treatment helpful?
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Substance Use History

Please complete the following:

Have you ever or do you currently drink/use/abuse:	Last use	Amount and Frequency of use (i.e. 2 glasses, 5x a wk)	Age of first use?
Alcohol			
Marijuana			
Cocaine/Crack			
Amphetamines/ Methamphetamines			
Pills – If so, list:			
Other – Please list:			

Have you ever been annoyed when others talk about your drinking/drug use? Yes or No

Have you ever felt guilty about your drinking or drug use? Yes or No

Have you ever drank or used upon awakening? Yes or No

Have you ever drank or used more amounts or over a longer period than intended? Yes or No

Have you had a persistent desire or failed attempts to cut down OR control drinking/using? Yes or No

Does it take more alcohol/drugs to feel the effect? Yes or No

Do you spend a large amount of time getting, using or recovering from alcohol/drugs? Yes or No

Have you given up or reduced important social, occupational or recreational activities due to alcohol or drug use? Yes or No

Have you continued to use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or made worse by alcohol or drugs? Yes or No

Have you experienced withdrawal symptoms upon quitting? Yes or No

Have you ever wondered if you have a problem with alcohol or drugs? Yes or No

12 Step History

Have you ever attended a 12 Step Meeting? (Alcoholics Anonymous, Al-Anon, Narcotics Anonymous, Nar-Anon, Cocaine Anonymous, Co-Dependents Anonymous, Adult Children of Alcoholics, Emotions Anonymous, etc) Yes or No

If so, please complete the following:

Meeting (AA, NA, Al-Anon, etc)	Date of last meeting	Frequency of attendance	Sponsor	Helpful?
			Yes or No	Yes or No
			Yes or No	Yes or No
			Yes or No	Yes or No
			Yes or No	Yes or No

Please list family members in your home:

Name	Relationship	Age	History of Mental Health Issues or Addiction	Understands your issues?
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Medical History
Please list all medical conditions:

Please list all medications you are currently taking for physical conditions:

Do you have allergies? (medicine, food, pollen, etc) If so, list:_____

_____

Please list your current medical doctors:
1.
2.
3.
4.
5.

Educational History

Did you complete High School? Yes or No Did you obtain a GED? Yes or No

College/University	Dates attended	Degree Earned

Employment
Current Position or Title:_____ Full or part time?_____
How long have you been in your current position?_____
How do you feel about your job?_____

Legal History

Charge:	Date:	Convicted?	Currently on Probation/Parole? If so, with who?

Religious/Cultural Issues

Do you have any religious or cultural issues that you would like to discuss as part of treatment? If so, please describe:

Did you attend any religious services when you were young?_____ Currently?_____
Comments:_____

Sexuality Issues

Do you have any concerns regarding sex or sexuality that you would like to discuss as part of treatment? If so, please describe:

Supports/Hobbies

Do you have supportive friends or family in your life? If so, list:

Please list any hobbies or activities that you are currently involved with:

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often…**
   Swear at you, insult you, put you down or humiliate you?
   OR
   Act in a way that made you afraid that you might be physically hurt?
   Yes or No If yes, enter 1_____

2. Did a parent or other adult in the household **often or very often…**
   Push, grab, slap or throw something at you?
   OR
   EVER hit you so hard that you had marks or were injured?
   Yes or No If yes, enter 1_____

3. Did an adult or person at least 5 years older than you **ever..**
   Touch or fondle you or have you touch their body in a sexual way?
   OR
   Attempt to actually have oral, anal or vaginal intercourse with you?
   Yes or No If yes, enter 1_____

4. Did you **often or very often** feel that…
   No one in your family loved your or thought you were important or special?
   OR
   Your family didn't look out for each other, feel close to each or support each other?
   Yes or No If yes, enter 1_____

5. Did you **often or very often** feel that…
   You didn't have enough to eat, had to wear dirty clothes and had no one to protect you?
   OR
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed to go?
   Yes or No If yes, enter 1_____

6. Were your parents **ever** separated or divorced?
   Yes or No If yes, enter 1_____

7. Was your mother or stepmother…
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   OR
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   OR
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes or No If yes, enter 1_____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes or No If yes, enter 1_____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes or No If yes, enter 1_____

10. Did a household member go to prison?
    Yes or No If yes, enter 1_____

Total Score:_____

Family History

Do you have a grandparent, parent, aunt/uncle, brother/sister or other family member that has mental health issues or substance dependence or substance abuse issues? If so, please name and describe:

Where did you grow up?_____

# of siblings:_____ Birth order: Youngest Oldest Middle Other:_____

Are your parents married or divorced?_____ How old were you when they divorced?_____

Are your parents living or deceased?_____

Any relevant information about your family and/or significant other (if applicable):

Briefly describe your level of satisfaction with your significant other (if applicable):

Please list any other relevant information about family:

Please discuss any additional information that you feel is important that was not covered in the previous questions:

Signature: **Date:**