



THERAPY SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the counselor and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. 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.

It is important to note that services can be emotionally and psychologically challenging, even painful. Sometimes you may feel worse before you feel better. On the other hand, counseling and psychotherapy have 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.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45 to 50-minute session per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation.

PROFESSIONAL FEES

My hourly fee is \$110 for the initial consultation and \$100 for ongoing sessions. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records

or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payments of your fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call the plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Manage Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become a part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over with they do with it once it is in their hands. In some cases, they may share the information with a national medical information data-bank. I will provide you with a copy of any report I submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run

out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you are available. If you are unable to reach me and feel that you can not wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist/psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions: information you and your child report about physical or sexual abuse; information shared with your insurance company to process your claims; where you sign a release to have specific information shared; if you provide information that informs me that you are in danger of harming yourself or others. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

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

Patient/Guardian Signature

Date

Natolie Gray, LPC 1840 Old Norcross Road, Suite 300 Lawrenceville, GA 30044
Adult Intake Form

Client Name _____
Home Address _____
Street City State Zip
Home Telephone _____ Is it okay to call? Yes _____ No _____
Work Phone _____ Is it okay to call? Yes _____ No _____
Cell Phone _____ Is it okay to call? Yes _____ No _____
Email Address _____ Is it okay to email you? Yes _____
No _____

Social Security Number _____ Birth date _____
Age _____ Male _____ Female _____
Marital Status S _____ M _____ W _____ D _____
Client Status: Employed _____ Full Time Student _____ Part Time Student _____
Highest Degree of Education _____
Religion _____
Employer _____
Occupation _____
Employment Address _____
Street City State Zip

Name of spouse _____
Social Security Number _____ Birth date _____
Age _____
Highest Degree of Education _____
Religion _____
Spouse's employer _____
Occupation _____
Employment Address _____
Work Phone _____ Is it okay to call? Yes _____ No _____
Cell Phone _____ Is it okay to call? Yes _____ No _____

Names and ages of children (if applicable):

Did you contact your insurance company to verify your benefits and let them know you were coming? _____
Deductible/year \$ _____ Has it been met? _____ Copayment/coinsurance/visit \$ _____ or _____ %

Did you receive an authorization number from your insurance company/EAP program?

Yes _____ No _____

Authorization number _____

Number of visits _____

	Insurance Information		For Secondary Ins. Only
Policy Holder's ID/SS#	_____	Policy Holder's ID/SS#	_____
Ins Co. Name	_____	Ins. Co. Name	_____
Policy Holder's Name	_____	Policy Holder's Name	_____
Relationship to client	_____	Relationship to client	_____
Policy Holder's Address	_____	Policy Holder's Address	_____
Policy/Group #	_____	Policy/Group #	_____
Policy Holder's DOB	_____	Policy Holder's DOB	_____
Male _____ Female _____		Male _____ Female _____	
Employer	_____	Employer	_____

How did you hear about our practice? _____

May we thank your referral source? Yes _____ No _____ If yes, referral address _____

Did you visit our website? _____ For what purpose? _____

When you decided to call us, where did you get our phone number? _____

Client Name _____

Date _____

Have you received mental health care previously? Yes _____ No _____

If so, name of therapist or group? _____ When? _____

What issues were addressed?

In your own words, what issues bring you here at this time?

Describe any major medical/physical problems:

List known allergies:

Primary Care

Physician _____ Phone: _____

Address _____

Date of last visit _____

List current medications prescribed by this doctor:

Medication	Daily Dose	Condition	Starting Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Psychiatrist, if applicable _____ Phone: _____

Address _____

Date of last visit _____

List current medications prescribed by this doctor:

Medication	Daily Dose	Condition	Starting Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Nearest relative or friend (not spouse) we may contact in case of emergency:

Name	Relationship	Phone
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InPowerment Incorporated

Natolie Gray, MA, LPC

AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize Natolie Gray, 440 South Perry Street, Lawrenceville, GA 30046
To release and disclose information from the clinical record of:

(Name of client/recipient of mental health services) (Date of birth)
to, and allow such information to be inspected and copied by:

(Facility/Provider)

(Address)

Nature of information to be disclosed: _____
(State specific nature of information to be disclosed)

For the purposes of: _____
(State specific purpose of information to be disclosed)

I understand that I may revoke this consent at any time. This authorization is valid until
_____.
(Date)

It has been explained to me that if I refuse to consent to this release of information, the
following are the consequences (specify, if any): _____ no information released and/or
_____.

A copy of this release shall have the same force and effect as the original.

(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this
information unless the person who consented to this disclosure specifically consents to such
re-disclosure.

InPowerment Incorporated

Natolie Gray, MA, LPC

INTAKE INFORMATION

PATIENT'S NAME _____
FIRST INITIAL LAST

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ PATIENT'S BIRTH DAY _____

INSURANCE INFORMATION

INSURED'S NAME AND ADDRESS _____

SS# _____ DOB _____

INSURANCE COMPANY _____

GROUP NO. _____ INSURED'S EMPLOYER _____

WORK NO. _____ REFERRAL SOURCE _____

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information shared with our staff psychiatrist and b) information you report about child physical or sexual abuse; then, by Georgia State Law, I am obligated to report this information to the Georgia Department of Children and Family Services, c) information shared with your insurance company to process your claims, d) where you sign a release to have specific information shared, e) if you provide information that informs me that you are in danger of harming yourself or others. If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client or the guardian understands they are to contact the emergency services in the community for those services. Natolie Gray will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s) _____ Date _____

Financial/insurance issues: As a courtesy, we will bill your insurance company, HMO or responsible party if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds, \$300.00, we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. Lastly, we ask that every client authorize payment of medical benefits directly to InPowerment Incorporated. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments, Please feel free to ask.

Signature(s) _____ Date _____