InPowerment Incorporated

Natolie Gray, MA, LPC

THERAPY SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business polices. 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

Child/Teen Intake Form for InPowerment Incorporated Natolie Gray, MA, LPC

1840 Old Norcross Road, Suite 300 Lawrenceville, GA 30044

Please note: the information you provide here is protected, confidential information

Client Name:
First_____Middle:_____Last:_____
Address:_____
City:_____State:_____Zip:_____
Cellphone:_____ May we leave a message? □Yes □No
Home Phone: _____ May we leave a message? □Yes □No

Names of parents/guardians:
Mother Name:
First_____Middle:_____Last:_____
(if different)Address:_____
City:_____State:____ Zip:_____
Email:_____Mobile:_____
May we email you? □Yes □No *Please note: Email is not considered to be a confidential form of communication.

Father Name:
First_____Middle:_____Last:_____
(if different) Address:_____
City:_____State:____ Zip:_____
Email:_____Mobile:_____
May we email you? □Yes □No *Please note: Email is not considered to be a confidential form of communication.

Parents: □ Married □ Separated □ Divorced
If divorced, what is legal custody
arrangement?_____

Child's Birth Date:_____ Age: _____ Gender: □ Male □ Female
School:_____Grade:_____

Pediatrician:_____Phone:_____

Psychiatrist (if
any):_____Phone:_____

Siblings:
Name:_____Age:_____Grade:_____

Name:_____Age:_____Grade:_____

Name:_____Age:_____Grade:_____

Please list the reasons you are seeking counseling:_____
_____
_____
_____
Referred by (if any):
_____

COUNSELING AND/OR PSYCHIATRIC HISTORY
Has your child or family previously received any type of mental health services?
□ No □ Yes, previous therapist/practitioner:
_____
If yes, briefly describe the experience:_____
_____

Is your child currently taking any prescription medication? □ No □ Yes If yes, please list, include dosage and dates:_____
_____

Has your child ever been prescribed psychiatric medication? □ No □ Yes
If yes, please list, provide reasons and dates:
_____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION
1. How would you rate your child's current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any health concerns:_____
2. How would you rate your child's current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please describe:_____

3. What types of physical exercise does your child get?_____
_____
How often per week?_____

4. Please list any difficulties your child might be experiencing with appetite or eating patterns._____

5. Is your child currently experiencing overwhelming sadness or depression? □ No □ Yes
If yes, please describe, noting dates/duration:_____
_____

6. Has your child ever, or is he/she currently, experiencing self-harming thoughts?
□ No □ Yes If yes, please describe, noting
dates/duration:_____
_____

7. Is your child currently experiencing anxiety, panic attacks or phobias? □ No □ Yes
If yes, please describe, noting
dates/duration:_____
_____

8. Describe any changes or stressful events your child may have experienced recently:
_____
_____

9. Describe any trauma history that your child may have
experienced:_____
_____

FAMILY MENTAL HEALTH HISTORY
In the section below identify if there is a family history of any of the following:

Please Circle	List Family Member
Alcohol/Substance Abuse yes/no……	
Anxiety yes/no……	
Depression yes/no……	
Domestic Violence yes/no……	
Eating Disorders yes/no……	
Obesity yes/no……	
Obsessive Compulsive Behavior yes/no……	
Schizophrenia yes/no……	
Bipolar Disorder yes/no……	
Suicide Attempts yes/no……	

ADDITIONAL INFORMATION
1. Briefly describe your child's academic strengths and
challenges:_____
_____
_____

2. Briefly describe your child's social functioning, noting any concerns you may have:
_____
_____
_____

3. Do you consider your family and/or your child to be spiritual or religious? □ No □ Yes
If yes, describe your faith or
belief:_____

4. What do you consider to be some of your child's strengths and weaknesses?_____
_____
_____

5. Please describe any concerns with family relationships:_____
_____
_____

6. Please describe how discipline is handled in your family (for example, time outs, loss of privileges) and any concerns you may have related to discipline:_____
_____
_____

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 redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.