Frank G. Pratt, III
Licensed Clinical Social Worker

New Client Intake and Informed Consent

Client Name _____
Last *First* *Middle Initial*

Mailing Address _____

City _____ **State** _____ **ZIP**_____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **Friend or Family Member**_____
(someone to call to get a message to you if you can't be reached)

Date of Birth _____ **Sex** _____ **Age** _____ **Race** _____

Social Security Number _____ **Are you retired?** Yes ___ No ___

Employer Name/Address_____
_____

In case of an emergency, who should be notified?

Name _____ **Phone Number** _____

Relationship to Client_____

If the client is a minor, or if he/she in an adult with a legal guardian, or if someone other than patient is responsible for payment, please fill in everything below. The person responsible for the bill must sign below.

Guarantor Name _____
Last *First* *Middle Initial*

Address:_____ **City/State/Zip**:_____

Date of Birth _____ **Social Security Number** _____

Relationship to Patient: _____

I hereby accept responsibility for all charges to the account of this patient

Guarantor's Signature: _____

 Please initial here to indicate that you have read this page: ____

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

I am very pleased that you have selected me to be your psychotherapist, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Background Information

The following information regarding my educational background and experience as a therapist is an ethical requirement of my profession. If you have any questions, please feel free to ask.

- Bachelors Degree, Psychology. University of the South, 1998
- Masters Degree, Social Work. University of Georgia, 2006
- Since 2006, I have been continuously employed in the Social Work field. I have worked with individuals diagnosed with sever mental illness in inpatient and outpatient settings during this time. I also worked for approximately two years as a Discharge Planner at a hospital.
- I have been licensed in Georgia as a Clinical Social Worker (License # CSW004202) Since January, 2010. I have been in private practice at Gordon Behavioral Sciences since January, 2013.
- I am a member of the National Association of Social Workers (NASW).

Theoretical Views & Client Participation

My role as your therapist is that of a guide. It is a common misconception that therapists give advice. Some things that therapist say might be considered as advice, even if the intent is to help a client work though his/her problems. In the end, everyone makes their own decisions, and is ultimately responsible for these decisions. My background and training, combined with therapeutic techniques will likely help you as you make these decisions. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and I talk about both during and between sessions. If you are seeing a psychiatrist or other medical doctor, it is important for you to take all of your medications, exactly as prescribed. If you feel you medications need to be changed, you must seek guidance from your physician before making any changes. Please avoid any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions.

The more of yourself you are willing to invest, the greater the return.

Please initial here to indicate that you have read this page: ____

Confidentiality & Records

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in paper (and possibly electronic) files, which are stored in our office, in a secure location. Your billing information is managed electronically in our computer system. The computer that stores your billing information is located in our office.

I will always keep everything you say to me completely confidential, with the following exceptions:

- You direct me to tell someone else and you sign a "Release of Information" form
- I determine that you are a danger to yourself or to others
- You report information about the abuse of a child, an elderly person, or a disabled individual who may require protection
- I practice alongside Frank G. Pratt Jr., MD, if you are also receiving services from Dr. Pratt, he will have access to your record. He may also be given access to your record if a psychiatric consultation is needed in your case, even if you have never seen Dr. Pratt in the past.
- If I am ordered by a judge to disclose information. In this case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential. If you have questions about these legal matters, please consult with an attorney.
- Please note that in couple's counseling, I do not agree to keep secrets. Information revealed to me by any individual or party may be discussed with everyone who is involved in therapy.

Please refer to the HIPPA statement at the end of this packet for more information.

Structure and Cost of Sessions

I am a Medicare provider. I am also "in network" with a few private insurance providers. If you are a Medicare beneficiary, you agree to pay your co-pay on the day of your visit (unless you have a Medicare supplement plan) If you are not covered by Medicare, you agree to pay my normal rates, unless prior arrangements have been made. Please ask me or a staff member for my current fee schedule.

Doing psychotherapy by telephone is not ideal, and needing to talk to me between sessions may indicate that you need extra support. If this is the case, you and I will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 5 minutes in duration will be billed at $4.00 per minute.

The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, or MasterCard are acceptable for payment. Our office will provide you with a receipt of payment, upon request. If you are a Medicare beneficiary, our office will submit all Medicare claims (and claims to supplemental insurance companies) for my services. You agree to pay any fees that are not paid for my Medicare. Please note that phone sessions are not covered by Medicare.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify our office at least 24 hours in advance. I reserve the right to charge you $50.00 for a missed session. Please note that Medicare and private insurance companies do not reimburse for missed sessions. You must pay for this fee yourself.

Please initial here to indicate that you have read this page: ____

In Case of an Emergency

My practice is considered to be an outpatient facility, and we are equipped to accommodate individuals who are reasonably safe and resourceful. I not available at all times after hours, and no other clinicians are available after hours to help my clients. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional arrangements, or transfer your case to a therapist or clinic with 24-hour availability. If you are experiencing an after-hours emergency or crisis, feel free to call me at 678-231-7789. I will do whatever I can to assist you, if I am available. If do not answer, I will generally return phone calls within 48 hours (excluding weekends.) If you have a mental health emergency, you agree that you will not to wait for me to call back. You agree to do one or more of the following:

- Call Ridgeview Institute at 770.434.4567, Peachford Hospital at 770.454.5589, or the Georgia Crisis and Access Line at 1-800-715-4225. These facilities have 24 hour crisis lines, with trained, qualified mental health professionals available, any time, day or night.
- Call 911.
- Go to your nearest emergency room.

Electronic Communication

If you have a question, or need to talk with me, please call my office during normal business hours. As a rule, I do not use e-mail or short message services ("SMS" or "text messaging") to correspond with clients, and I discourage clients from using these mediums to communicate with me. If you send me an e-mail message, I generally respond via. telephone. Please keep in mind that e-mail messages and SMS messages **are not secure**, and can be intercepted and read by individuals who are not affiliated with our office. In most cases, neither you nor I will know if an e-mail message has been read by an unauthorized individual. I cannot be held legally responsible or liable for any confidential or privileged information that is disclosed to unauthorized individuals via. electronic communication. Of course, there are risks associated with electronic communications that I may not be aware of.

After acknowledging and accepting the inherent risks of the use of electronic correspondence, you may voluntarily authorize me to occasionally send e-mail or SMS messages to you by signing the statement below. Keep in mind that I will not conduct any therapy sessions via. these electronic means. Correspondence via. these unsecure means should be limited to routine matters, such as scheduling appointments. Note that the use of electronic correspondence is never appropriate in an emergency situation. By signing below, you agree that you will not attempt to contact me via. electronic means to address an emergency or a crisis situation.

I understand the inherent risks of electronic communications, and agree to allow Frank Pratt III, LCSW, and anyone else from Gordon Behavioral Sciences to contact me via. electronic communications, such as e-mail and SMS messaging. I will not hold Frank Pratt III, LCSW and/or Gordon Behavioral Sciences liable for any harm that may result from the anticipated or unanticipated risks associated with the use of electronic communication.

I understand that I am not required to sign this statement.

_____

Signed

Please initial here to indicate that you have read this page: ____

Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients secret. As much as I would like to, for your confidentiality I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. It is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are mandated by my code of ethics, and are strictly for your long-term protection.

Given the nature of our therapeutic relationship, please do not send me "friend requests" on any social media platform, such as Facebook, Twitter, LinkedIn, etc. I will likewise refrain from sending any such requests to you via social media platforms.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of The National Association of Social Workers (NASW). If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the Georgia professional licensing board that governs my profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.

Please initial here to indicate that you have read this page: ____

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with me as your therapist, and you are authorizing me to begin treatment with you.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

Please initial here to indicate that you have read this page: ____

Notice of Health Information Practices

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

Introduction

Dr. Pratt and staff are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Dr. Pratt, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of information for public health officials charged with improving community health,
- A tool with which we can assess and improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of this office, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
    - Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
    - Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

We are required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclosure your health information after we have received a written revocation of such an authorization according to the procedures included in the authorization.

 Please initial here to indicate that you have read this page: ____

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer at (706) 234-0034

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.
For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff, may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

***Business associates*:** There are some services provided in our organization through contacts with business associates. Examples include, but are not necessarily limited to physician services in the emergency department and radiology, laboratory tests, and our transcription company. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
***Notification*:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
***Communication with family*:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
***Appointments*:** We may contact you to provide appointment reminders
Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid court order.

 Please initial here to indicate that you have read this page: ____

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Gordon Behavioral Sciences, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Gordon Behavioral Sciences, P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Gordon Behavioral Sciences, P.C. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Gordon Behavioral Sciences, P.C. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:
_____
_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept / decline the terms of this consent.

Patient (or legal guardian/representative) **Date**

Please initial here to indicate that you have read this page: ____