

# Evans Psychology Group, LLC

4571 C. Cox road · Evans, GA 30809 • 706-888-0299

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## Adult Intake Packet: Patient History

Date: \_\_\_/\_\_\_/\_\_\_ Client name: \_\_\_\_\_

Age of client: \_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ S  M  D  Other: \_\_\_\_\_ SSN of client: \_\_\_/\_\_\_/\_\_\_

Home Address: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Employer Name /Phone: \_\_\_\_\_

Emergency Contact Name/Address/Phone \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Email Address: \_\_\_\_\_

Can clinical information be sent to this email address? Yes/ No

Name of Spouse/parent: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_/\_\_\_/\_\_\_

Address/Phone same if no: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Name of School (if applicable): \_\_\_\_\_ Current or highest grade completed: \_\_\_\_\_

List any known health problems:

Date: \_\_\_\_\_ Treated For: \_\_\_\_\_

Please list current medications: \_\_\_\_\_

Reason for appointment: \_\_\_\_\_

List any previous psychological/psychiatric history: Date/Treated For:

Who referred you: \_\_\_\_\_ Phone: \_\_\_\_\_ PCP: \_\_\_\_\_

May we exchange medical information, including psychological, psychiatric, alcohol, and drug abuse diagnosis/treatment with these physicians:  Yes  No May we leave a message if we need to contact you by:  Home  Cell  Work

Your signature (Legal guardian, if patient is a minor): \_\_\_\_\_

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**INFORMED CONSENT FOR PSYCHOTHERAPY**

**Charges**

Rates vary by clinician (ranging from \$100 to \$150 per session, see Fee Schedule). Rates are \$150.00 for an initial evaluation, \$125.00 for 45-55 minutes sessions, and \$75.00 for a 30 minute session. In the event of hardship charges are negotiated. Insurance will be filed through our office. Deductible and co-payment are due at time of service. Payment can be made by check, cash, or credit card (MasterCard or Visa). If you ever have any questions regarding your insurance or payments, please address them with me. I hereby assign, transfer, convey payment and authorize said payment to be made directly to Evans Psychology Group, LLC for any medical, sick benefits or injury benefits payable by any party, organization, etc., for the completion of all outstanding obligations related to this condition. I further agree that this assignment will not be withdrawn or voided at any time until this account is paid in full. I understand that a \$20.00 service charge will be added for any check returned by the bank for insufficient funds. I understand that interest may apply to any unpaid balance at the rate of 1.5% monthly. I further understand that Evans Psychology Group, LLC reserves the right to place all unpaid debts, and all pertinent information necessary to collect these debts, on my account with an outside collection agency. Initial \_\_\_\_\_

**Cancelled or Missed Appointments**

If you wish to change or cancel an appointment we require a minimum **24-hour advance notice (during business hours, i.e., Monday's appointment to be cancelled on Friday)**. Anything less will result in a **\$75 fee** charged to your account. It costs you money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.) We don't charge you the actual cost for that appointment but rather a **\$75 fee**. Advance notice allows another client time to reserve it in place of you. Please be courteous and responsible. Thank you. If you fail to show for an appointment without notice all future appointments will be removed and a **\$75 fee** assessed to your account. You may re-schedule appointments again on a "first come, first service basis". If you miss three consecutive appointments by not calling 24 hours in advanced or not showing for the appointment, you will be referred to another clinician. I will give you a list of other doctors in the area that you could see. Initial \_\_\_\_\_

**Late Policy "15-minutes"**

Being later by more than 15 minutes will require you to either reschedule or wait for the next available opening. Initial \_\_\_\_\_

**Release of Information**

I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. I further understand that I can withdraw this concern for release of records/information at any time.

Initial \_\_\_\_\_

**Confidentiality**

The Health Information Portability and Accountability Act (HIPAA) is meant to insure that your records are maintained in a private and secure manner. My office treats these records as confidential property and they are not released without your written authorization. Exceptions and uses and disclosures are explained in the Georgia Notice Form. All information between practitioner and patient is held strictly confidential. There are legal exceptions to this as stated in the Georgia Notice Form. I have read and/or been offered a copy of the Georgia Notice Form and understand that information obtained during treatment may be disclosed based upon these ethical and legal requirements. All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling sessions. Initial \_\_\_\_\_

**Evaluation and Treatment**

I will evaluate your presenting problem in the first one or two sessions. Evaluations may involve testing. I will inform you of my observations and treatment recommendations. Treatment usually lasts 3-6 months. In the event of an emergency I may be reached at

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the above phone number. If I am not available or in the event of a life-threatening emergency call the Coliseum Life Line at 1.800.548.4221, call 911 or go to your local hospital emergency room. **Initial** \_\_\_\_\_

## **Consent for Treatment**

I authorize and request my practitioner to carry out psychological exams, treatment and/or diagnostic procedures which now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

Yes  No May we ask for information, exchange information and/or discuss your treatment with members of your family? If yes, with whom: \_\_\_\_\_

**I have read and understand each of the policies outlined above:**

**Signature(s):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **General Consent for Child or Dependent Treatment**

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner to deliver mental health care services to the patient. I also understand that all policies described in this statements apply to the patient I represent.

**Signature of legal Guardian/legal Representative:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Policy on court involvement**

Please be advised that during treatment, if the client should become involved in **any type** of court case (i.e., child custody), we will not appear in court, write a letter to the court, or have any involvement with court proceedings. We have found that becoming involved in the court process has a negative effect on the therapeutic alliance with the client. If you are looking for a therapist to be involved in a court/custody case, it may be in your best interest to find another therapist. If we should be subpoenaed, understand that we require a \$1000 retainer prior to any participation in the court process and charge \$200/hour for all involvement with the court process, including prep work, consulting with an attorney, travel time, and testimony.

By signing below, I understand and agree to this policy.

**Signature:** \_\_\_\_\_

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## INFORMED CONSENT FOR TELEHEALTH

### Definition of Telehealth:

Telehealth involves the use of electronic communications to enable clinicians of Evans Psychology Group, LLC to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information that I have already signed also apply to telehealth. Copy of Office Policies and Informed Consent can be provided.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. This practice utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth via VSee.
4. Your clinician follows the State of Georgia regulations for tele-health, as well as the respective board regulations (NASW) and ethics.
5. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. \*\* (N/A payment made by SAIL) Payment for Telehealth Services: Evans Psychology Group, LLC will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. The standard copay and/or deductibles would apply. In the event that insurance does not cover telehealth, you may wish to pay out-of-pocket, or when there is no insurance coverage. If needed, you can request a statement of service to submit to your insurance company.

Patient Consent to the Use of Telehealth: I have read and understand the information provided above regarding telehealth, have discussed it with my therapist, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Client's Signature/Date \_\_\_\_\_

**Fee Schedule**

Initial meeting/intake:

Psychologist fee: \$150

Licensed Counselor fee: \$120

Therapy sessions:

Psychologist fee: \$125

Licensed Counselor fee: \$100

Comprehensive Psychological evaluation:

Starting at \$1000

Medical records review or sending of medical records:

\$50 fee (but if this time exceeds one hour then the fee will be \$100)

Production of a new document (e.g., treatment plan):

\$100/hour

Cancellation fee (within 24 hours)/ No show fee:

\$75

By signing below, I understand and agree to this policy:

Signature: \_\_\_\_\_

**CREDIT CARD ON FILE**

I agree to have the following credit card information on file (in a secure file) and for it to be charged the **\$75 cancellation fee** when I have cancelled an appointment within 24 hours or no showed for an appointment. I also agree for my credit card to be charged for any other owed payments to Evans Psychology Group. **This includes if insurance does not reimburse or cover the full fee for intake, sessions, or psychological testing.**

Credit Card Type:  MasterCard  Visa

Name on Credit Card: \_\_\_\_\_

Number on Card: \_\_\_\_\_

3 Digit Security Code; \_\_\_\_\_

Zip code: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**Policy on when clients are feeling medically ill**

- Please be courteous to your clinician and other clients that the clinician sees and cancel your (or your child's) appointment if you (of they) have any type of contagious illness (i.e., cold, cough, strep throat, stomach virus, flu). Be advised that if the client is ill, the session will be cut short. To be courteous to you, I will always cancel (or offer to cancel) sessions when I am ill so that I do not get you or your family members sick (or provide you with that option).
- If you call the morning of the scheduled appointment \*Due to Illness of client\* you will not be charged the cancellation fee.
- However, if you call within two hours of the scheduled appointment to cancel, you will still be charged the cancellation fee. Please leave a voicemail on the office line if the office administrator is unable to pick up the phone or if it is prior to business hours.

By signing below, I understand and agree to this policy.

Signature: \_\_\_\_\_

**Adult Clinical Interview Guide**

Client Name: \_\_\_\_\_

DOB/Age: \_\_\_\_\_/\_\_\_\_ Race: \_\_\_\_\_ Gender (circle one): Male Female

Evaluation Date: \_\_\_\_\_

Presenting Problem (including onset, precipitating events, duration, course, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check any symptoms you currently experience:

- |   |  |
|---|--|
| <input type="checkbox"/> Problems with sleep                            | <input type="checkbox"/> Problems with Appetite                    |
| <input type="checkbox"/> Depressed Mood                                 | <input type="checkbox"/> Anger issues                              |
| <input type="checkbox"/> Decreased interest in activities               | <input type="checkbox"/> History or current issues with aggression |
| <input type="checkbox"/> Social Withdrawal                              | <input type="checkbox"/> Decreased Energy/Fatigue                  |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Impulsivity                               |
| <input type="checkbox"/> Anxiety/Panic Attacks                          | <input type="checkbox"/> Hyperactivity                             |
| <input type="checkbox"/> Self-Injurious Behavior (i.e cutting, burning) | <input type="checkbox"/> Problems concentrating                    |
| <input type="checkbox"/> Mania  | <input type="checkbox"/> Hallucinations                            |
| <input type="checkbox"/> Grandiose Thinking                             |  |
| <input type="checkbox"/> Decreased need for sleep                       |  |



**HISTORY**

**Psychiatric History: (including diagnoses, medications, and inpatient/outpatient treatment {type, dates, clinician, outcome}):** \_\_\_\_\_

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**History of Suicide/Homicide Attempts: (circle one) YES/NO If yes, provide detailed information (date, type/method, description, outcome, etc.):** \_\_\_\_\_

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**Family Psychiatric and/or Medical History:** \_\_\_\_\_

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**Alcohol and Substance Use History:** \_\_\_\_\_

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**Family History of Alcohol and Substance Use/Dependence:** \_\_\_\_\_

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**Medical History (please include illnesses, injuries, surgeries, allergies, and medications):**

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**History of Family Living Situations and General Family Information (including whereabouts and nature of relationships with immediate family members, including both biological parents and all siblings):**

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**Educational and Occupational History (include current education/employment):**

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## Legal History:

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## History of Abuse/Neglect/DFCS involvement/Traumatic Events/Bereavement/Loss?: (circle one)

Yes/No -- If yes, type/date/severity/duration/treatment:

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Only answer the following questions/checklist if there is a history of trauma(s) or bereavement:

N/A \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> Nightmares   | <input type="checkbox"/> Hypervigilance (watching out for danger)      |
| <input type="checkbox"/> When think about trauma, become very upset                               | <input type="checkbox"/> Feeling jumpy or startle easily               |
| <input type="checkbox"/> Intrusive Thoughts   | <input type="checkbox"/> Feelings of anger                             |
| <input type="checkbox"/> Problems concentrating   | <input type="checkbox"/> Flashbacks                                    |
| <input type="checkbox"/> Problems sleeping  | <input type="checkbox"/> Isolating yourself                            |
| <input type="checkbox"/> Avoiding thoughts/feelings related to trauma                             | <input type="checkbox"/> Feeling alone inside                          |
| <input type="checkbox"/> Avoiding people/places/activities related to trauma                      | <input type="checkbox"/> Thinking you will not live a long life        |
| <input type="checkbox"/> Forgetting parts of the trauma(s)  | <input type="checkbox"/> Being scared the bad thing will happen again  |
| <input type="checkbox"/> Having headaches/stomachaches/heart beating fast when think about trauma | <input type="checkbox"/> Problems feeling love/happiness/sadness/anger |

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**Sexual Orientation:** \_\_\_ Heterosexual \_\_\_ Lesbian \_\_\_ Gay \_\_\_ Bisexual \_\_\_ Other: \_\_\_\_\_

**Marital/Relationship Status:**

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**Do you have children?** \_\_\_\_\_ **If YES, how many and what are their ages?**

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**Spirituality/Religion:**

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**Social Support:**

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**What are your goals for treatment?**

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The following is to be completed by the clinician:

**Mental Status:**

**Manner and Attitude:** \_\_\_ Accessible \_\_\_ Evasive \_\_\_ Defensive \_\_\_ Euphoric \_\_\_ Irritable  
\_\_\_ Guarded \_\_\_ Frightened \_\_\_ Aggressive \_\_\_ Optimistic \_\_\_ Passive  
\_\_\_ Resentful \_\_\_ Other: \_\_\_\_\_

**Appearance:** \_\_\_ Neat \_\_\_ Disheveled \_\_\_ Appropriate Attire \_\_\_ Other: \_\_\_\_\_

**Physiological Signs:** \_\_\_ Relaxed \_\_\_ Restless \_\_\_ Tearful \_\_\_ Tense Posture \_\_\_ Agitated  
\_\_\_ Decreased Motor Activity

**Orientation:** \_\_\_ Time \_\_\_ Place \_\_\_ Person \_\_\_ Situation

**Eye Contact:** \_\_\_ Direct \_\_\_ Intermittent \_\_\_ Intense \_\_\_ Poor

**Verbal Answers:** \_\_\_ Appropriate \_\_\_ Rambling \_\_\_ Detailed \_\_\_ Circumstantial \_\_\_ Repetitive  
\_\_\_ Slow \_\_\_ Rapid

**Thought Content:** \_\_\_ Normal \_\_\_ Hallucinations \_\_\_ Delusions \_\_\_ Obsessions \_\_\_ Ruminating  
\_\_\_ Flight of Ideas

**DSM-V Diagnosis:**

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