HOLY FAMILY COUNSELING CENTER
4411 Suwanee Dam Rd, Suite 720
Suwanee, GA 30024 | (678) 993-8494

Karen Vetter
LPC

INTAKE FORM

We welcome you to Holy Family Counseling Center, a faith based, independent private practice. It is the goal of your counselor to help you through the difficulties you are experiencing by addressing the whole person and family with dignity. Your counselor will strive to form a collaborative relationship with you to assist you in finding healthy solutions to your problems. Although we are independent of the Catholic Archdiocese of Atlanta, Holy Family Counseling Center strives to serve its people by providing evidenced based mental health services that are consistent with Catholic teaching. These pages contain information regarding office policies. Please read them and discuss any questions with your counselor. Your signature where indicated signifies that you have read, understand, and agree to abide by these policies.

Please fill out the following forms to help us assess your needs:

Date: _____ Client(s) Name: _____

Street Address: _____

City: _____ State: _____ Zip Code:_____

You were referred by:

_____

Preferred phone to contact you: Cell: _____Home: _____Work: _____

Email: _____ Sex: M / F

Would you like to receive information from our email list? Yes or No

Marital Status: S/M/D/W Number of Years: _____

Is the client under age 18? Yes or No

If yes, Name of Parent/Legal Guardian bringing child to appointment: _____

IN CASE OF EMERGENCY CONTACT:

Name: _____Phone**:** _____Relationship**:** _____

LIST ALL FAMILY MEMBERS *(starting with self):*

Name	DOB	School/Place of Employment	Relationship to Client
_____	____/____/_____	_____	_____
_____	____/____/_____	_____	_____
_____	____/____/_____	_____	_____
_____	____/____/_____	_____	_____
_____	____/____/_____	_____	_____

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CLIENT CONTRACT AND CONSENT

Client(s) Name: _____

Parent or Guardian_____

Counseling Fees and Consent to Treatment: Counseling fee for each counseling session is $150.00.

If you wish to be considered for a discounted fee based on financial need, please indicate your gross annual family income below. This will be discussed with your counselor at your first session.

Gross Annual Family Income (including child support, trusts, inheritance, disability, etc.)

$25,000 or less	_____	$55,000 to $70,000	_____	$100,000 to $115,000	_____	Over $150,000	_____
$25,000 to $40,000	_____	$70,000 to $85,000	_____	$115,000 to $130,000	_____		
$40,000 to $55,000	_____	$85,000 to $100,000	_____	$130,000 to $150,000	_____		

CONTRACT TERMS AND CONDITIONS (please initial each)

____ 1. I agree to pay a counseling fee of $150.00 for each 50-minute session. If I qualify for a discount, the counseling fee will then be $_____. I understand that to qualify for a discounted counseling fee, I will need to provide my counselor with the requested documentation which may include a copy of my latest tax return and/or pay stub. I understand that any discounted counseling fee will be reevaluated every 6 months or as the conditions of my income change and that this discounted counseling fee may also change.

____ 2. I understand that **payment is due at the time of service.** If you are unable to keep an appointment, **kindly give 24 hours' notice**, or the counseling fee agreed upon will apply and be charged.

____ 2b**. I understand that if my counseling fees are being paid for by a third party and if I fail to give 24 hours' notice before missing an appointment, I am responsible for payment of the counseling fee to Holy Family Counseling Center for the missed appointment. If I do not pay the counseling fee for the missed appointment, the third party will be notified accordingly.**

____ 3. I understand there will be a $25.00 returned check fee.

____ 4. I understand that Holy Family Counseling Center and its therapists, counselors and social workers are considered "out of network" providers and are not paneled with any insurance companies.

____ 5. I have read The Privacy Policy and Informed Consent which follows.

____ 6. **IN CASE OF EMERGENCY**, please go to your nearest Emergency Room or call 911.

____ 7**.** I understand that Holy Family Counseling Center services do not include court case appearances. If we are subpoenaed for any reason, there will be a special rate assessed for this service. **Please be aware that court involvement can have a deleterious effect on the therapeutic relationship.**

____ 8. I understand that all information disclosed within session(s) is confidential and may not be revealed to anyone outside Holy Family Counseling Center without my written permission. The only exception is in situations where disclosure is required by law:

a) If I present an imminent threat of harm to myself or to others.
b) When there is an indication of abuse of a child or vulnerable adult.
c) If I become gravely disabled.
d) By court order or subpoena.

By signing this form, you are affirming that you have read, understand, and agree to its contents.

_____ _____/_____/_____

(Signature of Client(s) and parent or guardian) **(Date)**

PRIVACY OF INFORMATION POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties: State and Federal law require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before the policy changes were made. Any changes in this notice will be made available upon request before changes take place. The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us, and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information: Information about you may be used by Holy Family Counseling Center personnel for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care professionals who provide you with treatment, such as doctors, nurses, mental health professionals, mental health interns, and mental health professionals or business associates of Holy Family Counseling Center such as billing, quality enhancement, training, audits, and accreditation providers. Both verbal information and written records about a client cannot be shared outside Holy Family Counseling Center without the written consent of the client or the client's legal guardian or personal representative. There are certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements. _____***Initial***

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person or persons, the mental health professional is required to warn the intended victim(s) and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety: Health records may be released for judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, military, and when complying with worker's compensation laws.

Abuse: If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or crime, and your safety appears to be at risk, we may be required to share this information with law enforcement officials to help prevent future occurrences and to help apprehend the perpetrator.

Prenatal Exposure to Controlled Substances: Mental health professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Professional Misconduct: Professional misconduct by a mental health professional must be reported by other mental health professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the mental health professional's actions, related records may be released to substantiate disciplinary concerns.

Judicial or Administrative Proceedings: Mental health professionals are required to release records of clients when a court order has been placed. There must be consent for our counselors to disclose information which the couple or family deemed therapeutic or necessary for treatment of the individual, couple, or family. Holy Family Counseling Center services do not include court case appearances. If we are subpoenaed for any reason, there will be a special rate assessed for this service.
Please be aware that court involvement can have a deleterious effect on the therapeutic relationship.

By signing this form, you are affirming that you have read, understand, and agree to its contents.

Client Signature/Date:

_____

INFORMED CONSENT FOR COUNSELING SERVICES

Name_____ Date_____/_____/_____

Services and Staff: I understand that Holy Family Counseling Center is a professional agency offering a wide range of counseling services, and that these counseling services are provided by licensed psychotherapists, master level therapists/counselors, certified addiction counselors, and graduate level interns. In all cases, trainees are supervised by licensed mental health professionals. Unless you have otherwise designated, all cases are discussed within a team supervision setting in order to enhance and assure your quality of care. In addition to providing direct counseling services, Holy Family Counseling Center provides training and consultation.

Confidentiality: I understand that all information disclosed within session(s) is confidential and may not be revealed to anyone outside Holy Family Counseling Center without my written permission. The only exception is in situations where disclosure is required by law:

1. If I present an imminent threat of harm to myself or to others.
2. When there is an indication of abuse of a child or vulnerable adult.
3. If I become gravely disabled.
4. By court order or subpoena.

Electronic Mail: With respect to electronic mail (e-mail), I understand that e-mail is not a confidential means of communication. Furthermore, Holy Family Counseling Center cannot ensure that e-mail messages will be received or responded to if my counselor is not available. I understand that e-mail is not the appropriate way to communicate confidential, urgent, or emergency information, or to schedule/modify/cancel appointments unless you have arranged this with your counselor.

Emergency: Go to the nearest Emergency Room or call 911.

Risk and Benefits: I understand that there is a possibility of risks and benefits which may occur in counseling. Counseling may involve the risk of remembering unpleasant events and may arouse strong emotional feelings. Counseling can impact relationships with significant others. The benefits from counseling may be an improved ability to relate with others; a clearer understanding of self, values, and goals; increased academic productivity; and an improved ability to deal with everyday stress. Taking personal responsibility for working through these issues increases the likelihood of greater growth.

Eligibility, Appropriateness, Referrals: The delivery of services from Holy Family Counseling Center to me shall be contingent upon whether the counselor and I can agree that the services are appropriate given the needs and conditions I present. If it is decided that Holy Family Counseling Center is not the appropriate agency to meet my needs, I understand that I will be given referrals to resources more appropriate to my needs and goals.

I HAVE HAD THE OPPORTUNITY TO DISCUSS ANY QUESTIONS I HAVE ABOUT THIS INFORMATION.

Client's Signature: _____Date_____/_____/_____

I HAVE DISCUSSED THIS INFORMATION WITH THE CLIENT.

Staff Signature: _____Date_____/_____/_____

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INITIAL ASSESSMENT (Please print)

(Page 1 of 2)

Date: ____/____/_____ **Client:** _____

Each client must complete a separate assessment. For example, husband, wife, and child each fill out a separate form.

1. **Do you have any chronic medical conditions or serious illness?** ___ Yes ___ No. If yes, please describe.

_____

2. **Are you taking any medications?** _____ Yes _____No. If yes, which ones? _____

_____

For how long and for what reason?

_____

Any allergies or drug sensitivities?

_____

3. **Do you have military experience**?_____Yes _____ No. If yes, please describe: _____

_____

4**. Are you experiencing a great deal of emotional stress or problems in your life?**

_____Yes, a lot _____More than usual _____Occasionally _____Rarely

5. **Do you have relationship problems with (check all that apply):**

____Spouse/significant other _____Remarried family members ____Immediate Family ____Family of Origin

____Extended Family (In-Laws) ____People at work ____Specific friends ____Other _____

Check items that apply to your situation. Use C for current and P for past.

___headaches
___dizziness
___ tremors or tics
___ difficulty concentrating
___stomach trouble
___bowel trouble
___eating problems
___ appetite change
___weight loss or gain
___sleep problems
___always tired or fatigued
___nightmares
___family conflicts

___financial problems
___use of pornography
___sexual compulsions
___sexual problems
___drinking problems
___drug problems
___compulsive spending
___legal problems
___feel tense, uptight
___unable to relax
___anxiety /worries
___always worried
___feel loss of control

___feel like crying
___panicky feelings
___frightened, scared
___people are out to get me
___unusual thoughts
___anger/temper problems
___ready to explode
___irritable
___feel I will lose control
___angry a lot
___temper problems
___hyper/too much energy
___misunderstood

___hard time with friendships
___feel apart from people
___loss of interest in things
___can't make decisions
___put up a good front
___lonely
___low self esteem
___unable to have a good time
___depressed/down
___feel worthless
___suicidal thoughts
___suicidal actions

INITIAL ASSESSMENT (Please print)
(Page 2 of 2)

6. **How is your spiritual life right now**?

___In good shape ___Developing ___Needs a lot of work ___Very poor

7. **How many changes would you like to make in your life?**

__Very many __Several __A few __None

8. **Have you ever spoken with anyone** (psychologist, counselor, psychiatrist, etc.) **about any of your personal problems?**

(If yes, who and when?)

_____

_____

_____

9. **Please describe any past hospitalizations in a mental health facility**.

_____

_____

10. **Please list the things/problems or events that are creating the most stress in your life at the present time as well as significant losses and changes in your life.**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Goals in Counseling – Please list up to three goals you hope to achieve in counseling. Please be as specific as possible.

1. _____
2. _____
3. _____

11. **How strongly would you like to talk to a counselor here about any of your concerns?**

___very much ____much ___a little ___not really

12. Please state any other concerns, questions, or comments:

_____

_____

_____

_____

Credit Card Authorization Form

The following information will be kept confidential; however, it may be shared with the billing staff of Holy Family Counseling Center and our credit card processing company.

Cardholder Name: _____

Credit Card Type: _____ Visa _____ Master card _____ Discover (We do not accept American Express)

Credit Card Number: _____

Expiration Date: _____ Billing Zip Code: _____

Card Identification Number (last 3 digits located on the back of the credit card): _____

Amount to Charge: $ _____ (USD) per session. This includes the $_____(USD) counseling fee per 50-minute session and a $5.00 (USD) service charge per credit card transaction of $155.00 or less. This service charge will increase for any credit card transaction greater than $155.00.

I hereby authorize Holy Family Counseling Center to charge my credit card or bank account in conjunction with each date counseling services are provided. A receipt for each payment will be provided by my counselor and the charge from "Holy Family Counseling Center" will appear on my credit card or bank statement. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Holy Family Counseling Center in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing/session date. If the session date falls on a weekend, evening, or holiday, I understand that the payments may be executed within a week of client session. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Holy Family Counselling Center may at its discretion attempt to process the charge again within 30 days and agree to an additional $20 charge for each attempt returned NSF, which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company, so long as the transactions correspond to the terms indicated in this authorization form.

Cardholder Signature: _____Date:_____

Counselor Signature: _____ Date:_____

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LPC

Good Faith Estimate of Health Care Services

Patient Information

Date: _____

Patient(s) Name: _____ Date of Birth: ____/___/_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Preferred phone to contact you: Cell: _____Home: _____Work: _____

Email: _____ Preferred Contact: ____ By Mail ____ By Email

Patient Diagnosis

Primary Service Requested/Scheduled: Please see attached list of itemized services and fees.

Patient Primary Diagnosis: Z65.9 or _____**Secondary Diagnosis Code:** N/A

If scheduled, list the date the primary service will be provided: _____

____ Check here if this service has not yet been scheduled.

Date of Good Faith Estimate: ___/____/___

Summary of Expected Charges: See the itemized estimate attached for more detail.

Holy Family Counseling Center and its therapists, counselors and social workers are considered "out of network" providers and are not paneled with any insurance companies.

The following is a detailed list of expected charges for outpatient psychotherapy/counseling. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Estimate for outpatient psychotherapy/counseling.

Holy Family Counseling Center
4411 Suwanee Dam Road, Suite 720
Suwanee, Ga 30024
Tax Identification Number: 27-0997764

Provider:
Karen Vetter, LPC
678-993-8494
info@holyfamilycounselingcenter.com
National Provider ID: 1073227419

Please check the location(s) of where the client expects to receive outpatient psychotherapy/counseling.
_____ Marietta Office: 707 Whitlock Avenue, Building E18, Marietta, GA 30064
_____ Tele Health

Service Provided: Outpatient psychotherapy/counseling.
Diagnosis Code: Z65.9 - Unspecified Problem related to unspecified psychosocial circumstances.
Service CPT Code: 90889 or 90837. *Please circle the one that applies.*

Quantity of Sessions: Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es) or presenting clinical concerns.

Expected Cost: This Good Faith Estimate explains your therapist's rate for each service provided. Please note the expected cost is based on the fee multiplied by the number of sessions needed, as determined in collaboration with your therapist.

Total expected charges from Holy Family Counseling Center to be determined as stated above.

Additional Health Care Provider/Facility Notes:

The therapist and client have agreed to an adjusted fee for service of $_____ for CPT Code 90837 to begin on _____ and be reevaluated on _____. *Client and therapist, please initial here.* _____.

Good Faith Estimate - Table of Services and Fees

Patient Name: _____

Service Code (CPT Code)	Description	Fee for Service (Number of sessions will be determined as We progress with therapy)
90889	Initial Interview	$150
90832	Individual Outpatient Psychotherapy, approximately 30 minutes	$75
90834	Individual Outpatient Psychotherapy, approximately 45 minutes	$150
90837	Individual Outpatient Psychotherapy, approximately 50-60 minutes.	$150
90846	Family Psychotherapy without Patient Present, approximately 50-60 minutes.	$150
90847	Family Psychotherapy with Patient Present, approximately 50-60 minutes	$150
90853	Group Psychotherapy – per individual	$40
90832-95	Tele Mental Health – approx. 30 minutes	$75
90834-95	Tele Mental Health – approx. 45 minutes	$150
90837-95	Tele Mental Health – approx. 50-60 minutes	$150
Cancellation Fee	Your therapist requires cancellation notification 24 hours prior to your appointment if you are unable to keep your appointment. You are responsible for the fee of the missed appointment.	$150
Reproduction of Records	HFCC follows state guidelines for reproduction of records costs. These can be found under the Georgia General Assembly Unannotated Code §31-33-3.	$25.88 search fee Pages 1-20 $0.97 per page. Pages 21-100 $0.83 per page.
Bank Fee	Returned check fee	$25
Service Charge	Credit card service charge -charged per transaction $155 or less. This service charge may increase for any credit card transaction greater than $155.	$5

Total Estimate: This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.

Please note, our services do not include court appearances. If we are subpoenaed for any reason, there will be a special rate assessed for these services and a new Good Faith Estimate will be provided for that service.

Disclaimer:
This Good Faith Estimate shows the costs of items and services that are reasonably expected for your healthcare needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for at least $400 more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on the Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or (800) 368-1019.

Keep a copy of this Good Faith Estimate that we have provided to you in a safe place and/or take a picture of it. You may need it if you are billed a higher amount.

This Good Faith Estimate is not a contract and does not require the uninsured or self-pay individual to obtain the items and services from any of the providers or facilities identified in this Good Faith Estimate. Your signature below indicates that your provider (or provider's representative) has gone over this Good Faith Estimate with you and any questions or concerns have been addressed. Thank you.

_____ or _____
Patient's signature — Guardian/authorized representative's signature

_____ or _____
Print name of Patient — Print name of guardian/authorized representative

_____ _____
Date and time of signature — Date of signature.