solstice point
COUNSELING

SOLSTICE POINT COUNSELING, LLC

Client Contact & Information Form

Today's Date:_____/_____/_____ Driver's License#:_____

Client Age:_____ Client Gender: Male Female Client Date of Birth:____/____/_____

Client Name:_____NickName:_____

Client Address:_____

City:_____ State:_____ Zip code:_____

Client Cell Phone:_____ Can SPC use this number to contact you: Yes or No

Parent Cell Phone:_____ Can SPC use this number to contact you: Yes or No

Client Home Phone:_____ Can SPC use this number to contact you: Yes or No

Client Work Phone:_____ Can SPC use this number to contact you: Yes or No

Client Email:_____Can SPC use this email to contact you: Yes or No

Client Marital Status: (please circle) Single Married Divorced Separated Widowed

Years of Education: Last Grade completed:_____ (please circle one of the following if applicable)

Student, GED , Highschool Diploma , College(BS, BA), Graduate (MS, MA) , Doctorate, Tech school

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Emergency Contact (initial ____for consent to contact this person in case of Emergency)

In case of Emergency Contact:_____

Relationship:_____ Home/Cell Phone:_____

PARENT CONTACT (If minor)

Parent Name:_____ Cell Phone:_____

Parent Name:_____ Cell Phone:_____

Student Information (if currently enrolled)

Name of Student's School/College:_____ Grade:_____

EMPLOYMENT INFORMATION

Name of Employer:_____ Job Title:_____

SOLSTICE POINT COUNSELING, LLC

Medication History

Client Name:_____ Date:_____

Please list ALL Prescribed Medications: (LIST ALL MEDICATIONS TAKEN IN THE LAST YEAR)

If NOT on any medications, please initial: _____ I am not currently taking any medications.

NAME OF MEDICATION	REASON PRESCRIBED	NAME OF PRESCRIBING DOCTOR	DOSAGE/ FREQUENCY	Date(s) of Use

_____ _____
Client Signature Date

_____ _____
Solstice Point Counseling, LLC Staff Signature Date

SOLSTICE POINT COUNSELING, LLC

Client Insurance Verification Form

Please contact your insurance carrier PRIOR to your Initial appointment and Use this form to answer any questions concerning Insurance coverage for behavioral health.

Client Name:_____ DOB:_____

Insurer's ID#:_____ Insurer's Group #: _____

Insurance Name:_____

Insurance Phone# for benefits:_____

Insurer's Name:_____ DOB:_____

Insurer's Address: _____

_____

****

Client's Counselor:_____ _____

Initial New Client Appt Date:_____

Solstice Point Counseling, LLC

127 Abercorn Street, Ste 403
Savannah, GA 31401

SOLSTICE POINT COUNSELING, LLC

Authorization of Release of Information

Client Name:_____ DOB: _____/_____/_____

I, _____ Hereby authorize Solstice Point Counseling, LLC and its affiliates, its employees and agents, to release information and request information concerning with my:

___ Admitting Diagnosis ___Discharge Diagnosis ___Dietician/Nutritionist Notes

___Counselor Progress Notes/summary ___Summary of Treatment ___Group Progress Notes/summary

___Nursing Notes ___Medical Doctor/Physician Notes ___Summary of Referral for Treatment

___Substance Abuse Assessment/Recommendation ___ Other: _____

I _____ authorize the release of information and authorize communication from the following:

1._____ Relationship:_____

Phone #:_____Fax#: _____

2._____ Relationship:_____

Phone #:_____Fax#: _____

3._____ Relationship:_____

Phone #:_____Fax#: _____

4._____ Relationship:_____

Phone #:_____Fax#: _____

5._____ Relationship:_____

Phone #:_____Fax#: _____

This authorization is valid from this beginning date:_____ to this termination date:_____.

I understand that all information and records regarding my treatment are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug abuse Patient Records (42CFR, Part2) and cannot be disclosed without my written consent unless otherwise provided in the Regulations. I understand that at any time, I may revoke this consent in person and in writing.

_____ _____
Client signature Date

_____ _____
Parent /Guardian signature (if minor) Date

_____ _____
Solstice Point Counseling LLC/Staff Signature Date

SOLSTICE POINT COUNSELING, LLC

Adolescent Informed Consent Form

Privacy of Information Shared in Counseling/Therapy:
Your Rights and My Policies

WHAT TO EXPECT:

The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

CONFIDENTIALITY CANNOT BE MAINTAINED WHEN:

›You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.

› You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.

› You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

› You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Georgia Department of Social Services.

› You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

COMMUNICATING WITH YOUR PARENT(S) OR GUARDIAN(S):

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of – or would be upset by – but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information

Adolescent Informed Consent Form

confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.

Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

[You should also know that, by law in Georgia, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.]

COMMUNICATING WITH OTHER ADULTS:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

Dietician/Nutritionist: Sometimes your dietician and I may need to work together; for example, if you need to start a meal plan, your dietician will be informed of the reason of initiating that plan etc. The only time I will share information with your dietician even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

EFFECTIVE DATE: _____

Client Signature (minor): _____

Parent or Guardian Signature: _____

SOLSTICE POINT COUNSELING, LLC

Adolescent Informed Consent Form

Adolescent Consent Form & Parent Agreement to Respect Privacy

Client Name:_____DOB:_____/_____/_____

***Adolescent therapy client:**

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature _____Date_____

*** **Parent/Guardian:** Initial boxes and sign below indicating your agreement to respect your adolescent's privacy:

/__/ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

/__/ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

/__/ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent Signature _____ Date_____

Parent Signature _____ Date_____

SPC Staff Signature _____ Date_____

SOLSTICE POINT COUNSELING, LLC

127 Abercorn Street, Ste 403 Savannah, Georgia 31401
Phone: 912-433-7829 Fax: 912-335-6590

SOLSTICE POINT COUNSELING, LLC

Informed Consent for Therapy Services - Adult

COUNSELOR-CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan or plan of referral. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. 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/referral with another mental health professional for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 45 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24-hour notice, my policy is to collect the FULL amount of the Individual session fees. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. If you are more than 15 minutes late, your appointment will need to be rescheduled and you will be billed the FULL amount of the session fee.

In addition, if client has missed two or more scheduled appointments, client will be referred to another counselor or treatment group for further counseling and/or treatment.

PROFESSIONAL FEES

The standard fee for the initial intake is $150.00-200.00 and each subsequent individual session range from $125.00-250.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by credit card (Visa, MasterCard, American Express, Discover) or Cash/Money order. For any outstanding balances, If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment AND discontinue services.

SOLSTICE POINT COUNSELING, LLC

Informed Consent for Therapy Services - Adult

For any outstanding balances, a pre-approved client credit card will be kept securely on file and utilized to pay any client balances. Failure to pay outstanding balances with in a 30-day period from date of services provided will also result in discharge and referral of client to another counselor and/or treatment professional.

In addition to weekly appointments, it is my practice to charge for telecommunication. An service fee of $50/15 minutes for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay ($500.00/ hour) for the professional time required even if another party compels me to testify. Our office prefers to avoid court litigation due to the complexities of confidentiality. Pease note that our counseling office can provide referrals for local counselors/social workers who are experienced in court proceedings.

INSURANCE

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 and if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If Solstice Point Counseling is an in-network provider, Solstice Point Counseling will file insurance claims for you and the contractual amount for reimbursements will be accepted. For insurances that are considered out of network, full payment of fees is expected at the time of services provided. In addition, if requested by client, after each session, I will supply you with a receipt of payment for services or the Super Bill, which you can submit to your insurance company for reimbursement. Solstice Point Counseling, LLC does NOT submit super bills/claims to insurance carriers or file claims to insurance companies as an out of network provider. If clients desire to submit claims to their insurance carrier for reimbursement, Solstice Point Counseling, LLC will provide a super bill to you, the client. Client will then take on all responsibilities concerning Insurance claims.

This will typically mean that you will be responsible to pay for sessions with me for full amount of fees due. It is important to remember that you, the client, as filer for the superbill are seeking reimbursement from the insurance company not Solstice Point Counseling, LLC.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis.. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to be reimbursed with insurance.

If you prefer to use a participating provider, I will refer you to a colleague If I am not a participating provider for your insurance plan.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

SOLSTICE POINT COUNSELING, LLC

Informed Consent for Therapy Services - Adult

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

INTERNS

Our office provides clinical supervision and case management to on site interns. Interns are graduate level students who are working on a Master level degree in the mental health, professional counseling and/or social work field. They will be supervised both by our staff and by the administrators at their appropriate college and/ or graduate institution. Interns are kept to the same level of confidentially as our staff. Professional services provided by interns are optional and can be declined at any time by the client.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised. [See Adolescent Consent Forms if applicable].

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) go to your Local Hospital Emergency Room, or 2) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences. Our offices are not an emergency clinic and all emergency cases will be instructed to seek emergency treatment through a local emergency room or 911.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have dual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement of Services & Informed Consent along with the Notice of Privacy Practices and agree to their terms.

SOLSTICE POINT COUNSELING, LLC

Informed Consent for Therapy Services - Adult

Client Name:_____ DOB: ____/_____/_____

Patient's Acknowledgement of Receipt of Informed Consent and Policies and Procedures:

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of Solstice Point Counseling, LLC "Notice of Privacy Practices."

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

_____	_____	_____
Client Printed Name	Client Signature	Date
_____		_____
Solstice Point Counseling, LLC/Staff Signature		Date

SOLSTICE POINT COUNSELING, LLC

127 Abercorn Street, Ste 403 Savannah, Georgia 31401
Phone: 912-433-7829 Fax: 912-335-6590

SOLSTICE POINT COUNSELING, LLC

Notice of Privacy Policies

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS

AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED,

AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records <u>without</u> Consent or Authorization

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, some because of the policies of Solstice Point Counseling, LLC, and some required by law. If you wish to receive counseling/mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

- Emergency If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
- Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Georgia law to report the matter immediately to the Georgia Department of Social Services.
- Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Georgia law to immediately make a report and provide relevant information to the Georgia Department of Welfare or Social Services.
- Health Oversight: Georgia law requires that licensed professional counselors report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Georgia Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.
- Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice."

SOLSTICE POINT COUNSELING, LLC

Notice of Privacy Policies

Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court- ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety: Under Georgia law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, or law enforcement officer, whether you are a minor or an adult.
- Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
- Records of Minors: Georgia has a number of laws that limit the confidentiality of the records of minors. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors.
- Staffing and supervision: Supervision and case management staffing is part of continuity of care at our office. At times your case may be supervised by a licensed professional counselor for clinical supervision purposes only.
- Counselor Interns: Counseling Interns are master level graduate students earning their graduate degree in counseling, mental health, and or social work. At times, counseling Interns may observe counseling sessions, provide supervised client services, provide group or individual counseling services, and/or aid clients in completing assessments. All interns are supervised by a licensed counselor.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

- Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
- Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process
- Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.
- Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical

SOLSTICE POINT COUNSELING, LLC

Notice of Privacy Policies

information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

- Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

****

Client Name: _____ DOB: ____/_____/_____

Patient's Acknowledgement of Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form.

I read the Notice of Privacy Practices and can be provided a copy of Solstice Point Counseling, LLC "Notice of Privacy Practices."

I have opted to RECEIVE e a copy of Notice_____ (initial) I have opted to DECLINE copy of Notice_____ (initial)

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

_____ _____
Client Signature Date

_____ _____
Client Printed Name Date

_____ _____
Solstice Point Counseling, LLC / Mieke P. Kramer, LPC Date

SOLSTICE POINT COUNSELING, LLC

127 Abercorn Street, Ste 403 Savannah, Georgia 31401
Phone: 912-433-7829 Fax: 912-335-6590

SOLSTICE POINT COUNSELING, LLC

Individual Mental Health Assessment

CLIENT NAME:_____DATE: _____

REFERRED BY:_____

Client Age:_____ Birthdate:_____ Gender: M / F Race:_____

Marital Status: Single Divorced Separated Married Widowed

PERSONAL HISTORY

What is the reason that brings you to counseling?

_____

_____

_____

How long have you had this problem?

_____

Please list any important events in your life that may relate to this problem:

_____

_____

_____

_____

_____

_____

How serious is this problem?

□mildly □moderately □very □extremely

What have you tried to do to solve this problem?

_____

_____

_____ _____

SOLSTICE POINT COUNSELING, LLC Staff Date

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Individual Mental Health Assessment

What has been successful in the past to solve this problem?

_____

_____

Have you had counseling/therapy in the past? □Yes □No

If so, where? _____ when? _____

What was helpful about the counseling?

_____

_____

Education:

Level of Education completed: _____

Are you currently a full-time student? Yes or No

If yes, what school do you attend? _____

Vocation:

Are you currently employed? _____ Type of Work:_____

Average hours worked wkly _____ Current Position: _____

FAMILY HISTORY

What is the age of your parents: Dad _____ Mom _____

Are both parents still living? Yes Or No How many siblings in your family? _____

What are the ages of your brothers (#, age) _____

What are the ages of your sisters (#, age) _____

_____ _____

SOLSTICE POINT COUNSELING, LLC Staff Date

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Individual Mental Health Assessment

Which members of your family are you close to?

_____

_____

Are there any family members who are a problem for you?

_____

_____

Early Childhood: Please list any important events that occurred during your childhood:

_____

_____

_____

_____

Describe your Relationship with parents, siblings, spouse, children:

_____

_____

_____

_____

Current living situation / Who currently lives in the home with you?

_____

_____

MARITAL/RELATIONSHIP HISTORY

What is your current marital status: _____

How long have you been married or together: _____

_____ _____

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Individual Mental Health Assessment

If you have been divorced, number of marriages and divorces:

_____

Reason for divorce/separation:

_____

How many children do you have?_____

Ages and Gender of children:

_____

Sexual Orientation: homosexual heterosexual Other:_____

RELIGIOUS HISTORY

Are you spiritual? _____

Do you go to church? YES or NO

If so do you have a denominational preference? _____

LEGAL ISSUES

Legal Problems:

Have you ever been arrested: YES OR NO

When/Charges:

_____

What if any pending legal cases/sentences do you currently have?

_____

_____ _____

SOLSTICE POINT COUNSELING, LLC Staff Date

SOLSTICE POINT COUNSELING, LLC

Individual Mental Health Assessment

CLIENT RISK ASSESSMENT

Is there a history of physical, sexual, or verbal abuse? (in the past or currently)

_____

_____

Is there a history of self-mutilation or self-destructive behaviors? (cutting, burning yourself, picking)

_____

_____

Is there a history of behavioral addiction? (gambling, eating disorder, sexual addiction, pornography)

_____

_____

Is there a history of Depression, Suicide thoughts, plans, or attempts? Is there any treatment for Depression or Mental Illness? If yes when?

_____

_____

CLIENT HISTORY OF EATING DISORDER and/or TREATMENT

Indicate any of the following that apply to you if answered yes to Eating Disorder:

(C) Current / (P) Past

_____/_____	Binge eating
_____/_____	Restrictive eating
_____/_____	Laxative/ Enema misuse
_____/_____	Diuretics/ Diet pills misuse
_____/_____	Distorted body image
_____/_____	Excessive exercising

_____ _____

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Individual Mental Health Assessment

_____/_____ Purging/self-induced vomiting
_____/_____ Amenorrhea
_____/_____ Changes in Body weight: gain or loss

Do you have a registered dietician that you see regularly? Yes or No

Have you ever received treatment for an Eating Disorder? Yes or No Please list below

TYPE OF TREATMENT	LOCATION OF TREATMENT	DATES OF TREATMENT

CLIENT HISTORY OF SUBSTANCE ABUSE TREATMENT OR MENTAL HEALTH TREATMENT

What is your current use of alcohol or other drugs?

_____

_____

Do you think you have an alcohol/drug problem? _____

Do you drink/use alone? _____

Have you ever been arrested because of alcohol or drug related charges? Yes or No

Does anyone in your family of origin currently or in the past have a drinking or drugging problem? Please explain:

_____

_____

Does anyone that you currently are in a significant relationship with have a drinking or

_____ _____
SOLSTICE POINT COUNSELING, LLC Staff Date

drugging problem? Please explain:

_____

_____

Have you ever received treatment for Mental Health Issues? Yes or No Please list below

Have you ever received treatment for Substance Abuse Issues? Yes or No Please list below

TYPE OF TREATMENT	LOCATION OF TREATMENT	DATES OF TREATMENT

MEDICAL HISTORY

How would you rate your current health?

Very poor 1 2 3 4 5 6 7 8 9 10 Very good

Any History of STD? Yes or No

Diagnosis of AIDS? Yes or No

List current health problems for which you are receiving treatment:

_____

_____

_____

_____

_____ _____

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Individual Mental Health Assessment

LIFE INDICATORS INVENTORY:

SEVERITY OF PROBLEM: 0=NO PROBLEM 5=DISABLING	INDICATE ANY PROBLEMS IN THE FOLLOWING AREAS:	EXPLAIN
0 1 2 3 4 5	Sleep too much	
0 1 2 3 4 5	Sleep too little	
0 1 2 3 4 5	Interrupted sleep	
0 1 2 3 4 5	Other sleep problems	
0 1 2 3 4 5	Memory	
0 1 2 3 4 5	Concentration	
0 1 2 3 4 5	Attention	
0 1 2 3 4 5	Loss of interest in usual activities	
0 1 2 3 4 5	Feelings of sadness	
0 1 2 3 4 5	Loss of energy	
0 1 2 3 4 5	Feeling tired all the time	
0 1 2 3 4 5	Periods of crying	
0 1 2 3 4 5	Feeling of hopelessness	
0 1 2 3 4 5	Loss of sexual desire	
0 1 2 3 4 5	Outbursts of anger	
0 1 2 3 4 5	Change in appetite	
0 1 2 3 4 5	Hearing voices when no person is present	
0 1 2 3 4 5	Unable to recall periods of time in childhood after age 5	
0 1 2 3 4 5	Unable to recall some period of your day	
1 2 3 4 5	Walking in sleep	
0 1 2 3 4 5	Nightmares	
0 1 2 3 4 5	Overwhelming fears	
0 1 2 3 4 5	Racing thoughts	
0 1 2 3 4 5	Thoughts that won't go away that are constantly in your head	
0 1 2 3 4 5	Thoughts of harming someone else	
0 1 2 3 4 5	Thoughts that some person or people are trying to harm you	

_____ _____

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0 1 2 3 4 5	Noticing items in your home and not knowing where they came from or how they got there	
0 1 2 3 4 5	Feelings of being controlled by forces outside yourself	
0 1 2 3 4 5	Feeling compelled to repeat activities for no reason	
0 1 2 3 4 5	Unable to relax	
0 1 2 3 4 5	Blackouts	
0 1 2 3 4 5	Excessive sweating	
0 1 2 3 4 5	Death of family members or friends	
0 1 2 3 4 5	Panic attacks	
0 1 2 3 4 5	Mood swings	
0 1 2 3 4 5	Spending sprees	
0 1 2 3 4 5	Changes in energy level	
0 1 2 3 4 5	Other:	

Please return completed form to your SPC staff and they will review the form with you at your initial appointments.

Thank you!

_____ _____

SOLSTICE POINT COUNSELING, LLC Staff Date