Initials______

**Metropolitan Psychotherapy Associates**
**2801 Buford Hwy NE, Suite 470**
**Atlanta, Georgia 30329**
**(404) 321-4954**

**Brittany Boden, LCSW • Sandra Hale, MA, LPC • Steve Harris, LCSW • W. Myles Hassler, MS, LPC • Heather McCormack-Moon, MA, LPC • Lisa Angert Morris, MS, LPC • Kathy Steele, MN, CS**

## NEW CLIENT INFORMATION

Name ________________________________________________ Date ________________

Primary phone number _______________________________________________________

Other phone number(s) ______________________________________________________

Email address ______________________________________________________________

Address ___________________________________________________________________

__________________________________________________________________________

County of residence _________________________________________________________

Date of birth _______________________ Height _____________ Weight ______________

Race/ethnicity ______________________________________________________________

Highest level of education ____________________________________________________

Place of employment _________________________________________________________

Occupation ________________________________________________________________

Who referred you ? __________________________________________________________
May I contact your referral if s/he is a professional? __________

**Relationship Status** (check one):

Single ____ Married/Committed Relationship ____ Widowed ____ Divorced/Separated ____

How long in married/committed relationship? _____________ Partner's age ______________

Partner's business or position __________________________________________________

Do you have children? ____ If yes, ages and genders _______________________________

**Medical History**

Local physician (name and number) _____________________________________________

__________________________________________________________________________

Date of last physical __________________________________________________________

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Current physical problems, symptoms or concerns ___________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Current prescription medications (name & dosage) __________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Prescribed by (physician name & number) _________________________________________

Date and nature of previous significant physical problems _____________________________

_____________________________________________________________________________

Currently in counseling or psychotherapy? Yes _________ No _________

If yes, name of therapist _______________________________________________________

Previous counseling or psychotherapy? Yes _________ No _________

For how long? ________________________When? __________________________________

Medication prescribed _________________________________________________________

Previous psychiatric hospitalization (where/when) ___________________________________

_________________________________________________ Length of stay ______________

Have any family members been hospitalized for psychiatric purposes? Yes ______ No ______

If yes, who? ________________________ When? ___________ How long? ______________

**Family Information**

Parental Status: Living together ________ Separated/Divorced ________

Father's age _______ If deceased, age and year of death ___________________________

Mother's age _______ If deceased, age and year of death ___________________________

Highest educational level attained by: Father _______________ Mother _________________

Father's most recent business or position __________________________________________

Mother's most recent business or position __________________________________________

Ages and Genders of siblings: ___________________________________________________

Are/were either of your parents alcoholic or drug addicted? Yes ______ No ______

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Are/were any of your siblings alcoholic or drug addicted? Yes ______ No ______

Are/were any of your grandparents alcoholic or drug addicted? Yes ______ No _____

Are/were any other family members alcoholic or drug addicted? Yes ______ No ______

Contact in case of medical or psychological emergency: **(Note:** *This person would only be contacted with your consent, or during life threatening circumstances.)*

Name ______________________________________ Relationship ____________________

Address ____________________________________________________________________

Main phone ___________________________ Other phone ___________________________

Briefly describe why you are seeking therapy at this time:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

What else might be important for your therapist to know?

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

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## Client Checklist

Please complete the following checklist. Check only those items which are **TRUE** or mostly true for you.

_______1. A life transition is causing me stress.
_______2. I have just had a major loss.
_______3. I have feelings of overwhelming panic and/or anxiety.
_______4. I am afraid that I'm losing my mind.
_______5. My mind keeps racing, and it is hard to shut out thoughts.
_______6. I am (or have been) seeing or hearing things that others don't see or hear.
_______7. I have disturbing nightmares.
_______8. I have done things to hurt myself physically (suicide attempts, self-mutilation, etc.).
_______9. I have serious thoughts of suicide.
_______10. My future seems hopeless.
_______11. I am very depressed.
_______12. My appetite is not like it used to be.
_______13. I have recently lost/gained a significant amount of weight.
_______14. I have sometimes vomited, fasted, or used laxatives or vigorous exercise in order to control my weight.
_______15. I have been told by a physician that I was too thin.
_______16. I have had an intense fear of gaining weight or becoming fat.
_______17. I have felt fat even though others have said I was thin.
_______18. I have had recurring periods of binge eating (rapid consumption of a large amount of food in a short amount of time).
_______19. I used to sleep normally (e.g. 7-8 hours) every night but now I sleep too much/too little.
_______20. I am concerned about issues of sexuality.
_______21. I sometimes use too much alcohol/drugs.
_______22. I have sometimes felt like I ought to cut down on my drinking/drug use.
_______23. I have sometimes felt bad or guilty about my drinking/drug use.
_______24. People have sometimes annoyed me by criticizing my drinking/drug use.
_______25. I have sometimes had a drink first thing in the morning to steady my nerves or get rid of my hangover.
_______26. I have had a sudden inability to recall important personal information (more than ordinary forgetfulness, not due to head trauma, stroke, seizure, or alcohol-related blackouts).
_______27. I have (past or present) experienced sudden unexpected travel away from my home or work place with the inability to recall my past (not due to head trauma, stroke, seizure, or alcohol-related blackouts).
_______28. I have (past or present) assumed a new identity, partial or complete (not due to head trauma, stroke, seizure, or alcohol-related blackouts).
_______29. I have had a persistent or recurrent experience of feeling detached from reality, as if I were an outside observer of my mental processes or body.
_______30. I have (past or present) had a persistent or recurrent experience of feeling like an automaton or as if in a daydream.
_______31. I have felt like there were two or more very different personalities within myself, each of which is dominant at a particular time.
_______32. I feel I have some gaps in my memory after the age of five.
_______33. When I was a child or adolescent, an adult overly criticized me, focused on my failures, belittled, and/or swore at me.
_______34. When I was a child or adolescent, an adult punched, bit, kicked, burned, or beat me.
_______35. When I was a child or adolescent, someone fondled me, exposed themselves to me such that I felt frightened, exploited me sexually, and/or attempted sexual contact when I did not want to participate.
_______36. As an adult, someone overly criticized me, focused on my failures, belittled, and/or swore at me.
_______37. As an adult, someone punched, bit, kicked, burned, or beat me.
_______38. As an adult, someone fondled me, exposed themselves to me such that I felt frightened, exploited me sexually, and/or attempted sexual contact when I did not want to participate.
_______39. I have recently been sexually assaulted.

**METROPOLITAN PSYCHOTHERAPY ASSOCIATES**
**2801 Buford Hwy NE Suite 470**
**Atlanta, GA 30329**
**404-321-4954**

## INFORMED CONSENT FOR PSYCHOTHERAPY

Therapy is a cooperative alliance that increases human understanding, improves relationships, and brings about needed change. Therapy works best when you put consistent effort toward self-reflection and change. It is not magic, nor is it simply about receiving advice. Many people's emotional struggles come from certain beliefs that prevent them from functioning at their best; from difficulties managing emotions, such as anxiety, depression, shame, or anger; from traumatic experiences; and from particular relational patterns that prevent good and stable relationships. Therapy will help you focus not only on what you think, feel, and do, but perhaps why you have these patterns, and what you can do to change them.

**Your Therapist's Responsibilities**

- CONFIDENTIALITY: With the exception of certain specific life-threatening situations, you have the absolute right to confidentiality of your therapy. Your therapist cannot and will not share your information with anyone else, or even that you are in therapy without your prior written permission. Under the provisions of federal regulations, your therapist cannot legally speak to another health care provider or a member of your family about you without your prior consent. You are also protected under the provisions of the federal Health Insurance Portability and Accountability Act (HIPAA). This law ensures the confidentiality of all electronic transmission of information about you. Whenever information about you is transmitted electronically (for example, information sent via email or fax), it will be done with special safeguards to ensure confidentiality.
- Your therapist agrees to practice within his or her level of competence, licensure guidelines, and ethical standard of practice. He or she maintains a license to practice psychotherapy in the state of Georgia and regularly attends continuing education programs. Your therapist is committed to therapeutic approaches that promote and sustain your highest level of functioning throughout the course of treatment. Should your therapist determine that your needs are outside his or her areas of competence, he or she will ensure that you are given adequate referrals to help you.
- Therapy should not be a mystery. You have the right to ask questions about anything that happens in therapy. Your therapist is willing to discuss how and why you are working in certain ways or with certain topics. He or she is willing to consider alternative that you might find helpful, so you can feel free to bring up additional possibilities.
- Your therapist will set a time to meet with you regularly, will be timely, and charge a fair fee that is commensurate with his or her experience and expertise, and within community standards.

**Your Responsibilities as a Client**

- You are responsible for coming to session on time and at the time you have scheduled. Sessions last 50 minutes, unless otherwise determined in advance. If you are late, your session will end on time. If you miss a session without canceling, or cancel with less than twenty-four hours notice, you will be charged the regular fee for that session. The only exception to this rule is if you would endanger yourself by attempting to come (for instance, driving on icy roads). If your therapist inadvertently misses a scheduled session, you will receive the next session free of charge.
- You are responsible for paying for your session at the time of service unless you have made previous arrangements with your therapist. Longer sessions or telephone calls over 10 minutes long will be billed at a prorated rate of your hourly fee.
- Generally, clients may not run a bill. However, under special circumstances, which should be discussed in advance, your therapist may temporarily allow a balance of up to three sessions. It is unethical for therapists to accept barter of any type in exchange for therapy. If your financial circumstances change, please let your therapist know immediately so that you can discuss the options together.
- You agree to participate actively in the therapeutic process by
    - collaboratively working on realistic and concrete goals;

- working on your issues between sessions, and
- being honest with your therapist. Remember, your therapy is only as good as the effort you put into it.

**Risks and Benefits of Therapy**
Therapy has potential emotional risks. Approaching feelings or thoughts that you have tried to avoid may be painful. Making changes in your beliefs or behaviors can be challenging, and potentially may affect (some of) your relationships. You may find your relationship with your therapist is a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits of change for you. Most people who take these risks find that therapy is helpful. Your therapist will inform you beforehand of any potential risks and benefits of any special treatment techniques, so that you may decide for yourself if it might be right for you. If at any time you feel an intervention is not helping, please let your therapist know immediately.

**Therapist Planned Absences**
Your therapist may be away from the office a number of times during the year. Our clients at MPA are always covered by another therapist whenever one of us is out of town or otherwise unavailable. Your therapist will always let you know well in advance of planned absences so that you may schedule around them to the degree possible. If the frequency of your therapist's absences is of concern to you, please initiate a discussion with him or her during your initial therapy sessions, or at such time as it becomes problematic for you.

**Emergency Policies**
Metropolitan Psychotherapy Associates is not a crisis or emergency center. If you have an urgent matter during office hours, call your therapist and he or she will return your call as soon as feasible. Generally calls are returned within 24 hours during the week. If you have not heard from your therapist in what you determine is a reasonable amount of time, or if you have a psychiatric emergency after hours, on weekends, or holidays, please call the Assessment Center at Ridgeview Institute at (770) 434-4567, the National Crisis Text Line (text 'CONNECT' to 741741), or 911.

**Inclement Weather**
Our general policy is to close the MPA office if DeKalb County Schools are closed for inclement weather. Sometimes a therapist will make exceptions, so be sure to communicate with your therapist if you have a question about whether you will meet. When in doubt about your safety, do not drive. You will not be charged for a missed session if you make a late cancelation due to unsafe weather conditions.

**Permitted Forms of Communication**

Secure and private communication cannot be fully assured utilizing cell/smart phone or regular email technologies. It is your right to determine whether communication using non-secure technologies may be permitted and under what circumstances.

Your use of any non-secure technologies (cell phones, email, texts, fax) to contact your therapist will be considered to imply consent to return messages to you via the same non-secure technology, pending further clarification from you. (For example, if you contact your therapist using your cell phone, consent will be implied that it is permitted to contact you on that cell phone).

Please check below which modes of communication are permitted and which are not permitted. This consent may be updated at any time should circumstances or preferences change.

*****Email or texting should <u>not</u> be used for urgent communication of any type***. Instead, call your therapist and leave a voice message. If your situation is life-threatening, or your therapist has not called back in what you consider to be sufficient time, choose one of the following, all of which are available 24/7:

- Assessment Center at Ridgeview Institute at (770) 434-4567
- National Crisis Text Line (text 'CONNECT' to 741741)
- 911

Initials______

***Transmission of video of any sort from Client to Therapist is not permitted***

In the event that you choose not to allow non-secure modes of communication, contact will only be made via wire to wire phone, wire to wire fax, or mail.

**Voice communication <u>to</u> Client's cell/smart phone for**:
Scheduling appointments ___Permitted ___Not permitted
Appointment reminders ___Permitted ___Not permitted
Between session contact ___Permitted ___Not permitted

**Voice communication <u>from</u> Therapist's cell/smart phone for**:
Scheduling appointments ___Permitted ___Not permitted
Appointment reminders ___Permitted ___Not permitted
Between session contact ___Permitted ___Not permitted

**Fax communication <u>to</u> Client's non-secure fax or E-fax for**:
Scheduling appointments ___Permitted ___Not permitted
Appointment reminders ___Permitted ___Not permitted
Between session contact ___Permitted ___Not permitted
If permitted, list fax number(s):_____________________

**Fax communication <u>from</u> Therapist's non-secure fax or E-fax for:**
Scheduling appointments ___Permitted ___Not permitted
Appointment reminders ___Permitted ___Not permitted
Between session contact ___Permitted ___Not permitted
If permitted, list fax number(s): 404-321-1928

**Text communication <u>to</u> Client's cell/smart phone for**:
Scheduling appointments ___Permitted ___Not permitted
Appointment reminders ___Permitted ___Not permitted
Between session contact ___Permitted ___Not permitted

**Text communication <u>from</u> Therapist's cell/smart phone for:**
Scheduling appointments ___Permitted ___Not permitted
Appointment reminders ___Permitted ___Not permitted
Between session contact ___Permitted ___Not permitted

**Contact via the Client's email for:**
Scheduling appointments ___Permitted ___Not permitted
Appointment reminders ___Permitted ___Not permitted
Between session contact ___Permitted ___Not permitted
If permitted, list email address(es):________________________

**Teleconferencing based communication to Client's portal for**:
Scheduling appointments ___Permitted ___Not permitted
Appointment reminders ___Permitted ___Not permitted
Between session contact ___Permitted ___Not permitted
If permitted, list permitted portal site(s):____________________

**Teleconferencing based communication from your Therapist's portal for:**
Scheduling appointments ___Permitted ___Not permitted
Appointment reminders ___Permitted ___Not permitted
Between session contact ___Permitted ___Not permitted
If permitted, list permitted portal site(s):____________________

Initials______

**SIGNATURE(S)**

### Client Consent to Psychotherapy, Forms of Communication, and Acknowledgement of HIPAA Notice

Your signature below indicates that you have read the information provided in this Psychotherapy Information Disclosure Statement and have indicated your Permitted Forms of Communication above, and agree to abide by these terms during the course of your therapy.

Your signature also serves as an acknowledgement that you have read the HIPAA Notice Form regarding your Protected Health Information provided to you in the office.

**Signature______________________________________________ Date________________**

***Additional Signatures for Couples or Families***

**Signature______________________________________________ Date________________**

**Signature______________________________________________ Date________________**

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### Permission to Provide Information for Continuity of Care

We at Metropolitan Psychotherapy Associates have an ethical responsibility to provide clients with resources in the rare circumstance of a sudden inability to continue practice due to a therapist's incapacitation or death. Therefore, your therapist is requesting consent for your name, contact information and records to be made available to other partners at Metropolitan Psychotherapy Associates in case of such an event. We have a plan in place that allows MPA partners to notify you and help make arrangements for you to continue your therapy, should your therapist suddenly become unable to continue practice for any reason. Your information will be held in a secure and confidential location and will be accessed by MPA partners only in the event of your therapist's incapacitation or death.
Should you choose not to give consent for your information to be shared, you fully understand that it would be impossible for you to be contacted about your therapist.

**_____I give my consent to provide information for a professional will**
**_____I do NOT give my consent to provide information for a professional will**

**Signature _____________________________________________ Date_________**