Robin Day, LPC
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Client Information & Consent to Treatment

Today’s date ___________________ Date of Birth _____________

Your (legal) name ____

Street Address ____

City ____ State ________ Zip ______________

Cell Phone __________________________________ Other Phone _________________________

Referred by ____

Emergency contact name & phone ____

Briefly Describe Your Current Concerns/Difficulties

Medical History – Please note any significant medical problems, symptoms, or illnesses

Alcohol/Drug Use – Please note frequency and amounts

Previous mental health care, including psychiatric hospitalizations

Please briefly describe your current relationship with your family of origin (parents, siblings, grandparents)

Family members with suspected or know mental illness or substance dependence

Are you currently married or in a relationship? If yes, how satisfied are you in your current marriage or relationship?

Do you have children? If yes, what are their ages? Any known or suspected mental illnesses or substance dependence?

Legal status: Please describe any legal difficulties.

Coping Skills & Support: Briefly describe healthy activities which make you feel better. Also, please include with whom you talk when you are feeling down. (eg: reading, walking pets, al-anon, talking with sister)

Please put a check mark on any which apply.

Symptom/Concern/Problem	Currently (in the past month)	History
Excessive worry		
Social phobia/shyness		
Panic Attacks		
Irritability		
Verbal rage outbursts		
Violence towards others		
Excessive shame		
Negative self-statements		
Attention Deficit		
Inability to stay focused on a task		
Suicidal thoughts		
Suicide plan		
Suicide attempts		
Self-harm (cutting, burning, bruising)		
In a physical or sexually abusive relationship		
Thoughts of hurting others		
Hearing voices to harm self or others		
Childhood physical abuse		
Childhood sexual abuse		
Victim of physical assault as an adolescent/adult		
Victim of rape as an adolescent/adult		
Victim of natural disaster or other trauma		
Losing track in conversations		
Blackouts/memory loss without drugs/alcohol		
Flashbacks/intrusive traumatic memories		
Having “parts” or “alters”		
Frequently losing track of time		
Fragmented memories after age 6		
Auditory hallucinations		
Binge drinking		
Alcohol abuse or dependence		
Drug abuse or dependence		
Overeating or binge eating		
Under eating		
Purging (excessive exercise, laxatives, etc.)		
Sleeping too much		
Staying in bed all day		
Insomnia		

Medications

Date	Medication	Dosage	Physician

Consent to Treatment

I am looking forward to assisting you. The following 3 pages are designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Please know that your relationship with me a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

My Background

I graduated with my master's degree in community counseling from Georgia State University in 1994. I have been employed in a community mental health center (1995-1997, and 1998-1999), a private psychiatric hospital (1998), and a psychiatric rehabilitation center (1999-2001). In 1999 I obtained my license to practice psychotherapy independently in GA. In 2000 I began my private practice.

Theoretical Views & Client Participation

You are in charge of your goals for therapy. However, I may not agree to provide therapy for you if you are unable or unwilling to work on the goal of maintaining personal safety. Also, some behaviors, such as lying or excessive calling, may interfere with the therapy process and therefore must be addressed as goals for therapy.

It may take weeks, months, or years to achieve your goals for therapy. As a client, however, you may terminate therapy at any time. If you feel that another therapist--or no therapy at all—may better help you, I encourage you to bring this up in session.

Please be aware that you might feel worse before you feel better. Also, others in your life may not respond well to the changes you are making. I will work with you on the goal of minimizing discomfort during the change process.

Confidentiality & Records

In seeing me, you are agreeing to the creation of a "clinical record," which contains "medical record progress notes." Your records will be kept secure and not shared with anyone, except in the following circumstances: (1) you sign a "release of information" form; (2) I determine that you are in danger of serious harm to self or other(s); (3) you report abuse of a child, elderly person, or a disabled person who may need protection; and (4) a court order to release records is received. In the latter case, I will ask the court to honor the "privileged" nature of our communications. However, a court can chose to decline this request. In all cases, I will give out as little information as possible.

You may revoke a "release of information" form at any time. However, I retain the right to inform the third party that I can no longer communicate with him/her/them.

You can request at any time to see your medical record progress notes and documentation regarding any release of information about you to others. A copying fee will be charged if you want a copy of your medical record progress notes.

Structure and Cost of Treatment

I agree to provide psychotherapy for $110 per 50 minute initial assessment session. Follow-up sessions (after assessment) are $110 for regular therapy and $90 for GoalsFIRST for Women individual program sessions. I charge $35 per week for group participation. I charge $110 per hour for the creation of reports. I may charge for phone calls, and will discuss this with you before you are charged. Payment is due at the conclusion of the session. *Only cash and checks are accepted, no credit nor debit cards.*

I do not accept most insurances. After receiving payment, I will provide for you a receipt which you can submit to your insurance company for out-of-network reimbursement.

Cancellation Policy

I do charge the full fee for missed/cancelled appointments without a 24 hour notice. If you need to cancel an appointment, please do a leave a message on my cell phone at 404-323-0152. *This can cancellation policy does NOT apply to GoalsFIRST for Women™ groups and DBT coping skills group.* This exception is outlined below.

In Case of a Mental Health Emergency

While I do usually return calls made between 5am and 8pm within 2 hours, my practice is not geared towards crisis management. I you are unable to keep yourself safe between sessions, I will refer you to a higher level of care. Also, I am unavailable by phone for approximately 3 weeks each year. If you have a mental health emergency after 8pm or during one of my vacations, or if I do not return your call quickly enough, I recommend that you do one or more of the following:

- Call your psychiatrist
- Call 911
- Call or go to Peachford Hospital 770-455-3200
- Call or go to Ridgeview Institute 770-434-4567

The Professional Relationship

Due to the nature of our relationship and the ethical standards which govern my profession, the client-therapist relationship must remain the only relationship we have together. I cannot be your friend nor can I receive financial or other guidance from you. I am not able to accept gifts of significant monitory value.

Statement Regarding Ethics, Client Welfare, and Safety

My services will be provided in a professional manner consistent with the ethical guidelines of the GA Composite Board and the American Counseling Association. If at any time you have concerns about ethical or professional conduct, I invite you to discuss these issues with me immediately. If we are unable to resolve your concern, I will provide you with contact information for the GA Composite Board, which governs my profession.

Due to the nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so.

I may be important at times for me to communicate with others to help you remain safe. I generally ask for a release of information for your psychiatrist. If you have ongoing suicidal or other risk, I will also ask for a release for a family member or other supportive person. Be aware

that if you revoke your release for your psychiatrist or doctor, I may discontinue treatment with you.

<u>This section applies to clients who participate in a DBT Group or GoalsFirst for Women™ group</u>

Participants in DBT coping skills groups are required to see a licensed therapist or psychiatrist for individual, marital, or family therapy at least once per month. Participants in the GoalsFirst for Women™ groups *may* be required to see a licensed therapist or psychiatrist for individual, marital, or family therapy at least once per month. Be aware that risk assessments are not provided in my groups. My groups are not designed to help with maintaining personal safety. Other outside treatment is needed for that.

The $35 fee per group meeting is charged whether you come to group or not, regardless of the length of notice of absence and the reason for absence. I require a 2-week notice of discontinuation of the group. I charge a $70 deposit at your second group attendance. I use this deposit for your last 2 group meetings.

If you do not show up for 2 group meetings and do not call me to discuss your group participation, I will assume that you have discontinued the group and open your space in the group to others.

At your initial assessment I will also give you a handout on group rules. Please review these.

I look forward to helping you on your journey towards healing and growth. If you have any questions about this document, please ask.

I have read and understand all 3 pages of this consent to treatment.

____ ____________________
Client Legal Name (Please Print) Date

____ ____________________
Signature of Client Date

____ ____________________
Signature of Therapist Date

NOTICE OF PRIVACY PRACTICES (HIPPA)

A full explanation of my health information privacy practices is available for you to read and/or download from my website, www.robindaylpc.com. I can also provide for you a printed copy. Please do not hesitate to ask questions about this policy.

I acknowledge that I have accessed the Notice of Privacy Practices of Acceptance & Change, Inc. dba "Robin Day, LPC" from the company website or that I have received a copy from Robin Day, LPC

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Client Legal Name (Please Print)

____ _______________

Signature of Client Date

____ _______________

Signature of Therapist Date