INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

Client Name: _____ **Date of Birth:** _____

Home street address:

_____

City: _____ **State:** _____ **Zip:** _____

Place of Employment:

_____

Occupation: _____ **Work Hours Per Week:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions:

_____

Person(s) to notify in case of any emergency:
Name _____**Phone**_____
I will only contact this person if I believe it is an emergency. Please provide your signature to indicate that I may do so: **(Your Signature):** _____

Please briefly describe your current concern(s):

_____
_____
_____

Goal (s) for therapy?

_____
_____
_____
_____

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Email: kfreeman@threadsthreapeuticservices.com
Mailing Address: P.O. Box 921063 Norcross GA, 30010
Contact: (470) 519-2542

MEDICAL HISTORY

Please explain any significant medical problems, symptoms, or illnesses:

_____
_____
_____
_____
_____

Current Medication(s)

Name of Medication: [indicate dosage, purpose, and name of prescribing doctor]_____
_____
_____
_____

Do you smoke or use tobacco? ☐ **YES** ☐ **NO** If YES, how much per day? _____

Do you consume caffeine? ☐ **YES** ☐ **NO** If YES, how much per day? _____

Do you drink alcohol? ☐ **YES** ☐ **NO** If YES, how often per day/week/month/year? _____

Do you use any non-prescription drugs? ☐ **YES** ☐ **NO** If YES, what kinds and how often? _____

Previous Hospitalizations: (Approximate dates and reasons):

_____
_____
_____

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Have you ever talked with a psychiatrist, psychologist, or other mental health professional?
_____**YES** _____ **NO**

(Please list approximate dates and reasons):

_____

_____

Diagnosis: (if any) _____

FAMILY:

Mother: _____ Relationship: ☐ Good ☐ Fair ☐ Poor

Father: _____ Relationship: ☐ Good ☐ Fair ☐ Poor

Are your parent's (check one) _____Married _____Divorce ____Widowed ____Never Married

Were there any other primary caregivers who you had a significant relationship with? ☐ **YES** ☐ **NO**

If so, please describe how this person may have impacted your life:

_____

_____

_____

_____

How many siblings do you have? _____ Please list below:

Relationship: _____Good _____Fair _____Poor

Religious Affiliation:

_____

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RELATIONSHIP STATUS:

Are you currently dating? ☐ **YES** ☐ **NO**

How Long? _____ Relationship Satisfaction: 1 2 3 4 5 6 7 8 9 10

(1 indicates the relationship is unsatisfactory and 10 notes it is extremely satisfactory)

Married/Life Partnered? ☐ **YES** ☐ **NO**

How Long? _____ Relationship Satisfaction: 1 2 3 4 5 6 7 8 9 10

(1 indicates the relationship is unsatisfactory and 10 notes it is extremely satisfactory)

Spouse: _____Age _____Occupation _____

Previously Married/Life Partnered? _____**YES** _____**NO** Duration of previous marriages/committed partnerships _____

Do you have children? ____**YES** ____**NO**

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Describe any problems any of your children are having:

_____

_____

_____

_____

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THREADS THERAPEUTIC SERVICES

PLEASE check all that apply:

- ☐ Anxiety
- ☐ Crowds
- ☐ Nausea
- ☐ Psychiatric Hospitalization
- ☐ Parents
- ☐ Abdominal Distress
- ☐ Mood Changes
- ☐ Thoughts of Hurting Others
- ☐ Fainting
- ☐ Anger or Temper
- ☐ Dizziness
- ☐ Marriage/Partnership
- ☐ Panic
- ☐ Friend(s)
- ☐ Diarrhea
- ☐ Fears
- ☐ Co-Worker(s)
- ☐ Shortness of Breath
- ☐ Irritability
- ☐ Employer
- ☐ Chest Pain
- ☐ Concentration
- ☐ Finances
- ☐ Lump in the Throat
- ☐ Headaches
- ☐ Legal Problems
- ☐ Sweating
- ☐ Loss of Memory
- ☐ Sexual Problems
- ☐ Excessive Worry
- ☐ Dizziness
- ☐ History of Child Abuse
- ☐ Muscle Tension
- ☐ Learning Disabilities
- ☐ Depression
- ☐ Makes Careless Mistakes
- ☐ Feeling Manic
- ☐ Joint Pain
- ☐ Trusting Others
- ☐ Nightmares
- ☐ Communicating
- ☐ Drugs
- ☐ Caffeine
- ☐ Allergies
- ☐ Alcohol
- ☐ Fidgets Frequently
- ☐ Sleeping Too Much
- ☐ Head Injury
- ☐ Heart Palpitations
- ☐ Eating Disturbances
- ☐ Domestic Violence
- ☐ Blackouts
- ☐ Severe Weight Loss
- ☐ Paying Attention
- ☐ Chills or Hot Flashes
- ☐ Sexual Abuse
- ☐ Domestic Violence
- ☐ Hyperactivity
- ☐ Completing Tasks
- ☐ Suicide (Attempts)
- ☐ Thoughts of Suicide
- ☐ Lack of Impulse Control
- ☐ Waiting Your Turn
- ☐ Children
- ☐ Frequent Vomiting
- ☐ Getting to Little Sleep
- ☐ Nervous Breakdown
- ☐ Severe Weight Gain
- ☐ Easily Distracted by Noises

Any additional information you would like to include:

_____

_____

_____

_____

_____ _____

Client Signature **Date**

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Welcome to Threads Therapeutic Services, LLC *(TTS)*. We are very pleased that you selected our practice for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist or group leader, policies regarding confidentiality and emergencies, and several other details regarding your treatment here at *TTS*. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic journey. Please know that your relationship with your therapist or group leader is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Consent to Treatment

I authorize and request that Threads Therapeutic Services, LLC provide psychological examinations, treatment and /or diagnostic procedures for myself|my child, which now or during the course of my care as a client are advisable. The frequency and types of treatment will be decided between my therapist and me. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from psychotherapy, but there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy and that the process can sometimes be uncomfortable. I am able and willing to resolve all mental health problems that are assessed.

Consent to Treatment of Minors

I hereby represent that I have the legal authority to obtain medical and psychological treatment for the minor child for whom I am requesting treatment. I am a biological parent or legal guardian. In group home or foster family settings, I am designated to authorize treatment. If divorced, I am the primary custodial parent and can secure treatment without the authorization of the other parent.

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Client Participation

It is our belief that as people become more aware accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist at any point.

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without your therapist. We also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit. If at any point you are unable to keep your appointments or we don't hear from you for one month, we will need to close your chart. However, reopening your chart and resuming treatment is always an option.

School-Based Participation

Depending on the client's life circumstance they are unable to meet at our main office, we may provide services in the client's educational environment. Each case will be looked at individually by the therapist and clinical director to evaluate if school-based services is good-fit for the client and the family. If school-based services are provided, family participation is expected at least once per month in our office. If the family does not attend their office session, school-based services will be stopped immediately.

Confidentiality & Records

Your communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be stored electronically and secure inclusive of a signed HIPAA Business Associate Agreement (BAA) (as needed).

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Limits of Relationship and Confidentiality

Your therapist will always keep everything you say to him or her completely confidential, with the following exceptions: (1) you direct your therapist to tell someone else and you sign a "Release of Information" form; (2) your therapist determines that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) your therapist is ordered by a judge to disclose information.

Couples Counseling

Please note that in couple's counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Child Therapy Separated/Divorced Family

Please understand that your child is the client – not you, any other sibling or my spouse. This is true no matter who pays for the evaluation/treatment of my child. It is your responsibility to provide information regarding custody arrangements and contact information of the other parent. TTS's primary responsibility is your child's best interest and may decide to involve you in your child's evaluation/treatment at their sole discretion.

The therapist may contact the other parent of your child for informed consent for treatment or background information at any time during treatment. TTS therapist is not agreeing to be an expert witness or to testify on my behalf or on the behalf of any other individual other than your child at any deposition, court proceeding, or in any other way. Should the therapist be subpoenaed, you are responsible for any costs associated with the subpoena.

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Structure and Cost of Sessions

Release of information and Authorization for Payment:

I hereby authorize TTS to release information regarding my condition and treatment to the insurance carried by the client. I authorize payment or medical benefits to the TTS clinician for services provided.

E-Mail or Scan a copy of you (photo ID) driver's license and the front and back of your insurance card for authorization of services

Payment:

The fee for each session will be due at the beginning of each session. Preferred Payments **(No Personal Checks)** however; Zelle, Visa, MasterCard, Discover, or American Express are acceptable forms of payment, and we will provide you with a receipt of payment. If payment is not received promptly for services rendered, services may be suspended or terminated, pursuant to the ethical guidelines governing psychological care. In some extreme circumstances we may take Cash App (at our discretion).

Legal Proceeding:

If you become involved in legal proceedings that require TTS's participation, you will be expected to pay for all of the professional time, including preparation and transportation costs, even if TTS is called to testify by another party. (Because of the difficulty of legal involvement, TTS will charge $300.00 per hour for preparation and attendance at any legal proceeding.)

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify your therapist at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions. **The fee charged will be equal to the rate of the session.**

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In Case of an Emergency

TTS is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We are not available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call Cares Warm Line (844) 326-5400 8:30am-11:00pm (Substance)
- Covid-19-Hotline (844) 442-2681
- Call 911.
- Go to the emergency room of your choice.

Professional Relationship

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, your relationship with your therapist has to be different from most relationships. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature.

Statement Regarding Ethics, Client Welfare & Safety

TTS assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association and/or the American counseling Association and/or the National Association of Social Workers and/or the American Association for Marriage and Family Therapy. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately.

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Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. Therefore, we've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure or confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with your therapist.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. We realize that many people prefer to text and/or email because it is a quick way to convey information. **However, please know that it is our policy to utilize these means of communication strictly for appointment confirmations (nothing that could be inferred as therapy).**

Facebook, LinkedIn, Instagram, Pinterest, Twitter, Etc: It is our policy not to accept requests from any current or former clients on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality.

Google, Bing, etc.: It is our policy not to search for our clients on Google or any other search engine.

Faxing Medical Records: If you authorize us (in writing) via a "Release of Information" form to send your medical records or any form of protected health information to another entity for any reason, we may need to fax that information to the authorized entity. It is our responsibility to let you know that fax machines may not be a secure form of transmitting information.

Recommendations to Websites or Applications (Apps): During the course of treatment, your therapist may recommend that you visit certain websites for pertinent information or self-help. She or he may also recommend certain apps that could be of assistance to you and enhance your treatment.

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Consent to TeleMental Health Services

Please check the TeleMental Health services you are authorizing your therapist to utilize for your treatment or administrative purposes. You and your therapist will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying us in writing.

- ☐ Email
- ☐ Video Conferencing | Telehealth
- ☐ Website Portal
- ☐ Texting
- ☐ Recommendations to Websites or Apps

Our Agreement to Enter into a Therapeutic Relationship

We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask your therapist.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your therapist/group leader, and you are authorizing your therapist/group leader to begin treatment with you.

Youth and Adolescent ONLY

Parent Signature _____
Parent Name Print _____
Client Name Print _____
Date _____

Adults ONLY Signature Required

Client Signature _____
Client Name Print: _____
Date _____

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THREADS THERAPEUTIC SERVICES

CONSENT & AUTHORIZATION TO RELEASE INFORMATION (ROI)

Client Name: _____ **Date Of Birth:**_____

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below.

I, _____ (client), hereby authorize Kateece Freeman LPC, NCC |FFT, DBT, ART, CAMS II (therapist) and the following party or parties to discuss my mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnosis:

_____
_____
_____
_____
_____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

☐ The parties stated above may discuss my medical and/or mental health information without limitations.

☐ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows:

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Additionally, the above named parties, therapist & person(s) or entity (entities) designated under in the above documented outline agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named therapist/agency to be effective.

INSURANCE INFORMATION:

- **Primary:** _____
- **Secondary:** _____
- **Insurance TYPE:** _____
- **Identification #** _____
- **Group #** _____
- **Contact #** _____
- **Client Address**

  _____

  _____

Responsible party will be liable for all unpaid portions relative to fee(s) and balances not covered under insurance*

Youth and Adolescent ONLY

Parent Signature _____
Parent Name Print _____
Client Name Print _____
Date _____

Adults ONLY Signature Required

Client Signature _____
Client Name Print: _____
Date _____

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THREADS THERAPEUTIC SERVICES

Services Requesting (please circle)

Individual
Family
Couples
Group
Wellness
Mentorship

Anything additional to add:

_____
_____
_____
_____
_____
_____

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