TRANQUILITY COUNSELING SERVICES, LLC 210 CREEKSTONE RIDGE WOODSSTOCK GA 30188
770-278-9459
DR SHANNON BARNES; LPC, CPCS,
CLINICAL DIRECTOR

# Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected as confidential information.

**Personal Information**

Name:_________________________________________________ Date: ______________________

Parent/Legal Guardian (if under 18): ____________________________________________________

Address: __________________________________________________________________________

Home Phone: ___ _______________________________ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _________________________ May we leave a message? □ Yes □ No

Email: _________________________________________ May we leave a message? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: ______________________ Gender: ________________ Martial Status:______________

Employer: _____________________________________________ Title:____________________________

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**In Case Of Emergency: ______________________________ Phone: ________________________**

**I hereby grant any contracted treatment provider with Tranquility Counseling Services, LLC to contact the above named person in the event of an emergency. By signing below I agree to the release of my name, location, and nature of the emergency to this emergency contact. This release is valid through the duration of my treatment.**

____________________________________________________________ ______________________

**Signature** **Date**

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**History**

Have you previously received mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes,

Previous therapist/practitioner: __________________________________________

Are you currently taking any prescription or psychotropic medication? □ Yes □ No

If yes, please list:__________________________________________________________

How would you rate your current physical health?________________________________________

Specific Health Problems: ____________________________________________________________

How many times per week do you generally exercise? ____________________________________

How is your current appetite? __________________________________________________________

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

Do you drink alcohol more than once a week? □ No □ Yes

How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes How Long ? _______________

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? ___________

What significant life changes or stressful events have you experienced recently? _____________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________

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## Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

| | Please Circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes / no | ________________________ |
| Anxiety | yes / no | ________________________ |
| Depression | yes / no | ________________________ |
| Domestic Violence | yes / no | ________________________ |
| Eating Disorders | yes / no | ________________________ |
| Obesity | yes / no | ________________________ |
| Obsessive Compulsive Behavior | yes / no | ________________________ |
| Schizophrenia | yes / no | ________________________ |
| Suicide Attempts | yes / no | ________________________ |

## Additional Information

Employment: ________________________________________________________________________

Do you enjoy your work? Is there anything stressful about your current work? ____________________

________________________________________________________________________________________

________________________________________________________________________________________

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: ____________________________________________________

________________________________________________________________________________________

What do you consider to be some of your strengths? ________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

What do you consider to be some of your weaknesses? ______________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

What would you like to accomplish out of your time in therapy? ____________________________

________________________________________________________________________________________

________________________________________________________________________________________

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# Tranquility Counseling Services, LLC

## INFORMED CONSENT FOR ASSESSMENT, EVALUATION AND/OR TREATMENT

NAME: _______________________________________________Date of Birth: ____________________

Address: ___________________________________________ Phone Number:_____________________

I understand that l will be receiving an assessment, evaluation, and/or treatment from a Dr. Shannon Barnes, a contracted employee/colleague of Tranquility Counseling Services or an intern or therapist under supervision with Tranquility Counseling Services, LLC. The type and extent of services that I will receive will be determined following an initial consultation and thorough discussion with the treating provider. The goal of the assessment and/or evaluation process is to determine the goals I would like to accomplish through these services and to discuss how to accomplish those goals. Typically, treatment is provided over the course of several weeks.

**If this service is for a minor, by singing this consent you are confirming that you are the legal guardian and you have the legal right to make medical decisions for this minor. If requested you agree to provide documented proof of your guardianship**

Cancellation Policy: We require a 24 hour notice if an appointment needs to be canceled or changed. A no show/ cancelation fee may apply if a 24 hour notice is not given.

I understand that all information shared with Dr. Shannon Barnes, LPC or contracted employee/colleague/intern is confidential and no information will be released without my consent. During the course of treatment, assessment, or evaluation, it may be necessary for my therapist to communicate with others outside of Tranquility Counseling Services and consent to release information is given through separate written authorization. I understand that my case may be discussed through case consultation between my treating provider and Dr. Shannon Barnes for supervision purposes. I understand that my case information may be used for research purposes; however, my protected health information will not be used for research purposes.

Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, Shannon Barnes, LPC is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, Shannon Barnes, LPC is legally required to take steps to protect the child, and to inform the proper authorities.

C. When a valid court order is issued for records, Shannon Barnes, LPC and the agency are bound by law to comply with such requests.

I understand that while therapy may provide significant benefits, it may also pose risks. Therapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. I understand that my treatment provider is an independent contracted employee/colleague/intern of Tranquility Counseling Services and I understand that Tranquility Counseling Services, Dr. Shannon Barnes, and all other representatives, volunteers, shareholders, investors, or family members is not legally responsible for the actions of my independent treatment provider. I understand that providers contracted with Tranquility Counseling Services do not provide crisis treatment after hours and if I believe I am a danger to myself or others I will contact the Georgia crisis hot line at 1-800-715-4225 or call 911.

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## Tranquility Counseling Services , LLC

INFORMED CONSENT FOR ASSESSMENT, EVALUATION AND/OR TREATMENT

**Continued ……**

I understand that I may discontinue treatment at any time.  I understand that my file will be closed after treatment discontinues and after the standard allowed time, my file will be shredded.

I understand that my treatment provider does not become involved in legal cases, custody cases, or court cases.  If you attempt to involve your treatment provider this will incur a cost to you.  This may also be grounds for termination of services.

I understand that communication through texting, messaging, email (yahoo, gmail, Hotmail, etc) or other apps may not be a secure form of communication and my personal information could be at risk.  I agree that if I choose to utilize these forms of communication I understand the risks and I will not hold Tranquility Counseling Services at fault with liability. I understand that my treatment provider does not encourage this communication and is available by telephone or Tranquility email which is secure.

I understand that if my therapist is accepting my insurance, **by signing this form I am giving the therapist permission to file a claim on my behalf and to utilize any information needed in order to submit claims for processing.**  I also understand and agree that insurance companies will occasionally ask for my records, and my therapist will share clinical information if deemed necessary for the continuation of my treatment. I agree that all monies not paid by the insurance company is my responsibility. I understand that Tranquility Counseling Services will maintain a card on file, and will charge my card any outstanding balance owed for copays or non covered fees.  I also understand that Tranquility Counseling Services may utilize a third party billing entity to file insurance claims.

If I have any questions regarding this consent form or about the services I receive, I may discuss them with Dr. Shannon Barnes, LPC. I have read and understand the above. I consent to participate in the assessment, evaluation and/or treatment offered to me. I understand that I may stop treatment at any time.

By signing below I am agreeing to all provisions listed in this informed consent. I also understand that I give Dr. Shannon Barnes or contracted employer permission to collect and file insurance. I agree to pay all fees acquired that are not paid by my insurance company.  Any fees owed may  be paid with credit card, check, or money order.

_______________________________________________________          ___________________
Signature                                                                                   Date

_______________________________________________________          ___________________
Signature of legal guardian or representative                                 Date

_______________________________________________________          ___________________
Signature of Treatment Provider                                                     Date

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# LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

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## Duty Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. in cases in which the client discloses or implies ä plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

## Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a Child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

## Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

## Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

## insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____________________________________________
Client Signature (Client's guardian if under 18)

____________________________
Today's Date

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# Financial Policy
# Tranquility Counseling Services, LLC
# 210 Creekstone Ridge Woodstock GA 30188

Name: ____________________________________________ Date: _______________________
Address: __________________________________________________________________________
Phone Number: ____________________________________ DOB: ________________________

When you begin services with your therapist you will be placed in one of the following payment account categories:

1) If you choose not to use insurance benefits, or you do not have insurance benefits you will be placed in a private pay account category. The fee for your sessions will be agreed upon prior to your first session and all payments are due at the time services are rendered.

2) If you would like to use your in network or out of network insurance benefits and you **have met** your deductible, Tranquility Counseling Services will be happy to file your insurance claim. You will be placed in an insurance pay category. Any co-pays or coinsurance fees will be due at the time services are rendered. If your insurance claim is denied for any reason, you are responsible for paying the session fees. **(UMR clients please note: Tranquility will bill your claim; however, all session fees will be due at the time of service. Once payment is received from UMR you will be reimbursed. It can take up to 6 months for UMR to pay your claim.)**

3) If you would like to use in or out of network insurance benefits but you **have not met** your deductible; your session fee will be due at the time services are rendered. Tranquility will file your insurance for you so your fee will go toward your deductible.

4) If you choose to utilize Employee Assistance Program (EAP) benefits. You will be placed in an EAP category. Your EAP will be billed for all session fees. It is your responsibility to ensure that your therapist has your EAP company information, authorization number, and how many sessions are authorized. If the EAP refuses payment, you will then be placed in a private pay or insurance pay category and you will be responsible for any payments owed to the therapist.

Please Note:

- Tranquility counseling services requires a 24-hour notice if you cannot make your appointment time. A $25 late cancellation fee will apply if you do not provide a 24 hour notice. If you no show for your session the full session fee will be charged.
- Copays and other session fees may be paid with money order, check, or credit card. Please see the attached payment form. Fees are due at the time of service. Tranquility Counseling Services will maintain a card on file and charge this card as needed for outstanding co pays or fees.
- If your card is declined 3 times – your card will no longer be acceptable, and you will need to pay for sessions with a money order
- Cash is not kept on the premises.

By signing below, you are acknowledging and agreeing to this financial policy.

___________________ _______________________

___________________________________ __________________________
Client or Guardian/Representative Signature Date

**TRANQUILITY COUNSELING SERVICES, LLC**

**210 CREEKSTONE RIDGE WOODSSTOCK GA 30188 770-278-9459**

**DR SHANNON BARNES; LPC, CPCS, CLINICAL DIRECTOR**

# Payment Processing

Client Name: ____________________________________________ Date : ________________

Please carefully review the attached Financial Policy carefully and let your treatment provider know if you have any questions.

**YOU MUST PROVIDE CARD INFORMATION TO BE MAINTAINED ON FILE FOR INCIDENTAL CHARGES. IF YOU REFUSE TO PROVIDE CARD INFORMATION, THE FIRST FULL SESSION FEE OF UP TO $100 WILL BE DUE AT THE FIRST SESSION.**

Name of Card Holder: _______________________________________________________

Card Number: ______________________________________________________________

Exp Date: ________________ CVV: _____________________ Zip Code: _____________________

Signature of Card Holder: ______________________________________________

You may choose one of the following options to be executed at the time of services. Check and initial beside your choice.

________ I choose to provide a check for the initial deposit to be held on my account. I choose to pay with money order or paper check for copays or other fees at the time services are rendered. I agree to the information found on the financial policy regarding payments. If I do not pay fees/copays at the time services re rendered my card on file will be charged the balance due and an additional $4.00 per session bank fee. Please make checks payable to Tranquility Counseling Services, LLC.

________ I choose to maintain a card on file to be used for all session fees and copays. Charges will occur the same day or up to 10 business days. A $4 service fee per session will apply.

________ I choose to maintain a card on file; however, I request for my therapist to swipe my card at the time services are rendered. This will reduce the bank service fee to $2.00 per session.

***I agree that any monies owed, which are denied or not covered for any reason by my insurance plan, may be charged to the card listed above. If card information is not provided, I agree to pay any monies owed before further services are rendered.***

__________________________________________________________ ________________________

Client/Guardian Signature Date

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Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name

DOB:

I hereby acknowledge that I have been given an opportunity to read a copy of Tranquility Counseling Service's Notice of Privacy Practices located **on the website and client portal provided to me.** I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dr Barnes at 770-503-6448.

________________________________________ ________________________
Signature of Patient/Client Date