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:_____

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**

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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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.

Cancellation Policy: We require a 24 hour notice if an appointment needs to be canceled or changed. A $25 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.

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.

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INFORMED CONSENT FOR ASSESSMENT, EVALUATION AND/OR TREATMENT

Continued ……

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 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.

lf 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:

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.

3) If you would like to use in or out of network insurance benefits but you **have not met** your deductible; you will be placed in a private pay category and you will be provided a Superbill. A Superbill is a statement used by members to file a claim to their insurance company for credit toward the deductible or for reimbursement of fees paid out of pocket. Please note: The deductible/reimbursement fee typically differs from the private pay fee and you may not be credited or reimbursed the full amount of the private pay fee. Once your deductible has been met you will be moved to an insurance pay category.

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.
- 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

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Payment Processing

Client Name: _____ Date : _____
Please carefully review the attached Financial Policy carefully and let your treatment provider know if you have any questions. Please choose one of the following payment processing options. Initial beside your choice.

_____ I choose to allow Tranquility Counseling Services to maintain a credit card/debit card/ HSA card on file. Tranquility will process my payment with the card on file within one week of my session date. **I understand that a 2% processing fee will be applied.**

Name of Card Holder: _____

Card Number: _____ Exp Date: _____

Zip Code: _____ Signature of Card Holder: _____

_____ I choose to receive electronic invoices via my email and will pay online as soon as I receive the invoice. I understand if I do not pay my invoices within two days of receiving, I will be asked to provide a credit card for future payment processing. I also understand that the invoice must be paid before I return for my next session. **This option will not include an additional 2% fee.**

Invoice must be paid within 3 days of receipt. Continued late payments will result in the termination of this option.

My primary email (**checked regularly**) is _____.

_____ I choose to provide checking account information, so Tranquility Counseling Services can collect my fees electronically through my checking account via electronic check. I understand that an NSF fee may apply if my electronic check is returned. **I understand that this option will not include an additional 2% fee. And this option will include a savings of 5% deducted from my session fee.**

Name on Checking Account: _____

Routing Number: _____

Acct Number: _____

Signature of Checking Account Holder: _____

_____ I choose to pay with money order or paper check at the time services are rendered. I agree to the information found on the financial policy regarding payments.

_____ _____
Client 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