931 Monroe Dr. NE Suite A-102 423 ❖ Atlanta, Georgia 30308 ❖ Phone: (404) 585-0867

Date of intake:_____/_____/_____

CLIENT INFORMATION SHEET

Name _____ Date of birth _____/_____/_____ Age_____

Sex: Male/ Female Race/Ethnicity (optional) _____

Marital Status: Single Married Separated Divorced

Address _____

City/State/Zip _____ Home Phone _____

Email Address_____ Cell/Work Phone _____

Occupation _____Employers Name: _____

Name of your Primary Care Physician _____

PCP Phone: _____ PCP Fax_____

Referred By: (please circle) Physician, Yellow, Pages Friend/Family Other_____

May I contact or leave messages for the client or parent/Legal Guardian at the numbers listed above? Yes / No

If Client is under age 18 Please provide the Name of Parent/Legal Guardian Bringing Child to Appointment:
_____

Other people living in the home:

Name	Age	Relationship to Client

Emergency Contact: _____ Relationship_____
Complete Address: _____
Home Phone: _____Work Phone: _____ Cell Phone: _____
Spouse's Name (If not Emergency Contact): _____
Home Phone: _____Work Phone: _____Cell Phone:_____

1. Payment and Failed Appointments

I understand that all fees are due at the time of service. In other words, the full fee must be paid at the end of each session. The only exception to this is when insurance is being filed on my behalf; only the portion of the fee which the insurance is not expected to pay is due at the time of service, provided that all deductibles have been met.

I understand that The Wives Inc. has a 24-hour cancellation policy and I will be billed $50.00 for my missed appointment unless otherwise discussed with my therapist. I understand there will be a $25.00 service charge for all returned checks and that all additional collection expenses are my financial responsibility if the amount of the returned check plus $50.00 is not paid in cash within 30 days. **Outstanding accounts will be forwarded to a collection agency. I understand these charges are not reimbursable by my insurance and The Wives Inc. does not accept insurance at this time only cash, major credit-debit cards and checks.** I realize that my insurance policy is an agreement between me and my insurance company- not The Wives Inc. I take responsibility for all fees resulting from my treatment. I agree to pay any portion of the fee within 60 days and any collection costs encumbered should payment not be made promptly.

_____
Signature Client/Legal Guardian/Legal Representative

2. Client Rights and Responsibilities

Any person receiving services is entitled to:

1. Mental Health/Chemical Dependency services in accordance with standards of professional practice, appropriate to his/her needs and designed to give him/her a reasonable opportunity to improve his/her condition.
2. Humane care, protection from harm, and to be treated with dignity and respect.
3. The right to participate in the development and review of his/her treatment plan, including the known effects of receiving and not receiving such treatment, or alternative treatment, if any.
4. The right to receive treatment in the least restrictive settings.
5. The right to review his/her own record in the presence of the primary therapist, unless the primary therapist's professional judgment deems this to be potentially detrimental to the person.
6. The right to confidential maintenance of all his/her identifying treatment information; no disclosure of such information without his/her written authorization, except in cases of medical emergency, by court order, or when otherwise dictated by law.
7. The right to register complaints and to have his/her complaints heard and action taken, if required promptly.
8. The right to waive any of his/her rights, if the waiver is given voluntarily, knowingly, and in a competent state of mind. The waiver may be withdrawn at any time.

_____ _____

Signature of Client/Legal Guardian/Legal Representative Date

3. Consent for Treatment Authorization

I authorize and request my therapist to carry out psychosocial assessments, treatment and/or diagnostic procedures that now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my therapist can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that reactions will be worked on between my therapist and me. With these understandings, I hereby authorize treatment for myself. I give permission to The Wives Inc.-Natasha LaMarr to assist me in developing my treatment plan and provide treatment. In the event that I become ill or I am injured while on the premises, I authorize The Wives Inc.-Natasha LaMarr to provide or obtain emergency medical services (i.e. call an ambulance).

_____ _____

Signature of Client/Legal Guardian/Legal Representative Date

4. Consumer Consent for Use/Disclosure of Health Care Information

I understand that the consumer's health information is private and confidential. I understand that The Wives Inc.-Natasha LaMarr works very hard to protect the consumer's privacy and preserve the confidentiality of the consumer's personal health information. In general, there will be no uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. Examples would be if a consumer threatened to hurt someone of if child abuse is reported.

_____ _____

Signature of Consumer/Legal Guardian/Legal Representative Date

5. Business Policies and Procedures and Notice of Privacy Policies.

Your signature below acknowledges that you have been given a copy of The Wives Inc. Informed Consent, Business Policies and Procedures and a Notice of Privacy Policies. It also acknowledges that you understand these policies.

_____ _____

Signature of Consumer/Legal Guardian/Legal Representative Date