SweetwaterPractice
Counseling & Consulting

PATIENT INFORMATION

Patient's Name:_____

Date of Birth: _____ Age: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity: _____ Religion:_____

Home Address: _____

_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email: _____

Occupation: _____ ☐ Student

Employer (School, if student): _____

EMERGENCY CONTACT

Name: _____

Relationship to Patient: _____

Cell Phone: (_____)_____ Work Phone: (_____)_____

Are you currently working with any other practitioners? [ ] Yes [ ] No

If Yes, Name and Address:

Prior Counseling — Name(s) & Date(s):

Current Medications / Dosages (Include Over the Counter):

Have you had any problems with current or past medications? _____ If Yes, Details:

Any difficulty with drugs or alcohol now or in the past? (Legal, recreational, occupational?)

Major reason for seeking help at this time:

How long have you had these problems or symptoms?

Why did you seek help now?

What goals do you have for therapy?

Do you have any serious or chronic medical conditions? [ ] Yes [ ] No

If Yes, Dates & Details:

Have you had any serious accidents, head injuries, or seizures? [ ] Yes [ ] No

If Yes, Dates & Details:

Do you have any recurring nightmares? [ ] Yes [ ] No If yes, describe:

Who loved you unconditionally or gave you positive reinforcement from age 0 to 18?

Who loves you and supports you in your life now?

What is your spirituality?

What spiritual resources do you have, if any? By what name do you call your spiritual supports?

What characteristics do you like most about yourself?

What states of being do you want to live in or return to (peace, joy, creativity, freedom)?

Have you lost any parts of yourself you would really like to have back in your life?

Informed Consent

Everyone participating in therapy is entitled to ***confidentiality*** with certain exceptions. These include situations where a client presents a danger to him/herself, an expressed danger to others, or where the therapist suspects that abuse of a child under the age of 18, an elder over 65 or a dependent adult is occurring or has occurred.

Therapy involves both benefits and risks. The style of therapy I use is a combination of counseling, guidance, coaching, advice giving, education, and homework. We will establish goals for your treatment so that your needs and objectives are met. There are no guarantees with any form of therapy. You may feel worse before you feel better and/or your relationships may suffer as you begin to feel better. The possible risks include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy often requires recalling experiences, some of which may be unpleasant. Therapy may involve making changes that can feel uncomfortable to you and those close to you. Should you notice any negative effects, please tell us immediately.

Professional Conduct and Ethics: I agree to abide by the Ethical Standards of the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists. These standards are accessible on the Georgia Board's website http://sos.georgia.gov

Cancellations and Missed Appointments: Therapy appointments are made in advance and this time is held for you. If you are unable to attend a scheduled appointment, please give as much notice as possible. I require ***24 hours notice to cancel or reschedule*** an appointment. Without 24 hours notice, or if you are a "no show" for your appointment, you will be charged for your missed appointment.

Therapeutic Touch: On occasion, and only with your permission, we will use therapeutic touch during trauma therapy sessions. The touch may involve you remaining sitting on your chair or couch and receiving a supportive hand to hold, or the grounding touch of a hand on your shoulder, neck, or back. It is understood that therapeutic touch and the client-therapist relationship is always non-sexual and only happens if you as the client want or need it.

Insurance: We are what is referred to as an "Out of Network Provider." We do not bill your insurance company and payment is due at each session. However, we will provide a "Super-bill" if you are eligible for reimbursement from your insurance company. Services may be covered in full or in part by your health insurance company or employee benefit plan.

Telephone, text, and email policy: Generally, we ask that clients reserve discussing problems that arise between sessions for the next scheduled appointment time. We encourage you to use resources you have and to reach out to your support system. Unless there is an emergency, our schedules do not permit us to talk on the phone, respond to lengthy texts or answer lengthy emails in between sessions. If you feel the need to text or email information beyond the routine scheduling of appointments, we will wait to discuss the content in our next scheduled session. If telephone calls are necessary for a client emergency, please schedule a time for a telephone consultation, which will be charged at our regular rates (in 15-minute segments). I check voicemail and email Monday through Friday 9 AM-5 PM. To ***contact me between sessions***, please call and leave a message on my confidential voicemail. Videoconference technology is reserved for therapy sessions only. I will give you my business card with my contact phone number. Your call will be returned within the next business day. If you are having a life-threatening emergency, **please call 911 immediately**.

Divorce and/or Custody Cases: We ask all our clients waive the right to subpoena us to court. This policy is set in order that we can preserve the efficacy and integrity of our therapeutic progress and relationship with you. It is our experience that our appearance in court will damage the therapist-client relationship, and it is our ethical duty to make every reasonable effort to promote the welfare, autonomy, and best interests of our clients. By signing this agreement, you are waiving right to have us subpoenaed and agreeing in fact not to have our records or us subpoenaed. We will be happy to provide a referral to another therapist who will be willing to appear in court if needed as an alternative if you would prefer.

In the case we are subpoenaed to appear in court even with this waiver – whether we testify or not – we charge double our standard fee for Court Related work ($400/hour). Any of our time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the courthouse in addition to time on the stand as well as any travel time will be billed at $400 per hour. If we are requested for a half-day appearance, we require a 5-hour retainer of $2000. For a full-day appearance, we require a 10-hour retainer of $4000. All retainers must be paid in advance. As a general policy, we cannot be available "on-call," as being called to come to court at the last minute in that fashion is too disruptive to our practice, and not fair to our clients that otherwise would be scheduled that day, taking off time from work and/or taking their children out of school to come to our office.

Physical Examination: We strongly recommend that each client obtain a thorough physical exam prior to commencing therapy. This is especially important if you are suffering symptoms of anxiety or depression, headaches, and/or weight gain/loss. Symptoms may be biologically caused or may be there for a protective reason.

My fee is $200 for a 50-minute individual session. Payment is due at the end of each session.

Having read and understood the above, I agree to these conditions of our work together.

_____	_____
Name of Client	Therapist
_____	_____
Signature of Client	Signature of Therapist
_____	_____
Date	Date

INFORMED CONSENT FOR TELEMENTAL HEALTH

What is Telemental Healthcare?
Telemental healthcare includes the practice of diagnosis, treatment, education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making through the use of internet-based videoconferencing. Telehealth psychotherapy may include psychological health care delivery, consultation, coaching, and/or counseling. Telehealth psychotherapy will occur primarily through interactive audio, video, and telephone communications.

Risks of Telemental Health
1. Technological failure, such as unclear video, loss of sound, poor connection, or loss of connection.
2. Nonverbal cues are less readily available to both the therapist and the client.

Benefits of Telemental Health
1. Less limitations by geographical location.
2. Reduction of travel to a physical office, which includes decrease in travel time.
3. Participation in therapy from your own home or the environment of your choosing.

Telemental health delivery by Karen Hebert, LMFT, LPC may occur only with current residents of Georgia. The current laws that protect privacy and confidentiality also apply to telemental health. Any exceptions to confidentiality are described in the Informed Consent document.
All existing laws regarding client access to mental health information and copies of mental health records apply.

No permanent video or voice recordings are kept from telemental health sessions. Clients may not record or store videoconference sessions or face-to-face sessions without written permission.

Expectations of client during each session
1. Minimum bandwidth connection of 384 kb or higher.
2. Minimum resolution of 640x360 at 30 frames per second.
3. Operational web camera (HD 1080p is recommended).
4. Proper lighting and seating to ensure a clear image of each party's face.
5. Dress and environment appropriate to an in-office visit.
6. Only agreed upon participants will be present. The presence of any individuals unapproved by both parties and not part of the treatment plan will be cause for termination of the session.
7. Valid ID must be presented by the client during the initial consultation. In addition, a copy must be provided by the client for the medical file.
8. The client must disclose the physical address of their location at the start of the session. Unknown locations will be cause for termination of the session.
9. The client shall also provide a phone number where they can be reached in the event of service disruption.

Telemental health may not be the most effective form of treatment for certain individuals or presenting problems. If it is believed the client would benefit from another form of service (e.g. face-to-face sessions) or another provider, an appropriate referral will be made. If it would be beneficial for occasional face-to-face sessions with Karen Hebert, LMFT, LPC, this will be discussed as part of the treatment plan and the client has the right to refuse such a recommendation. This may result in a referral to another provider as well. All referrals will adhere to the Georgia Composite Board Code of Ethics for Licensed Professional Counselors and the American Association for Marriage and Family Therapy Code of Ethics.

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled. I have read and understand the information provided above. I have the right to discuss any and all of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

Other risks include but are not limited to:
Although all text messages, voice mail and email are kept confidential, choosing this method may lead to your information not being protected. If you choose to communicate with your therapist in this manner, you must understand the risk and consent to using the following email, cell, and text below.

I consent to using email communication using the following email(s):

_____

I consent to using text messages using the following cell number(s):

_____

I consent to my therapist leaving me voice mail messages on the above cell number(s):

YES _____ NO_____

Zoom Video
I consent to using Zoom for therapy. Yes _____ No_____

Emergency protocol
In the event of a medical or mental crisis event, Karen Hebert, LMFT, LPC, will contact the patient's emergency contact. If she cannot get ahold of that person, Karen will contact the client's local emergency services. The information provided will include the nature of the crisis and immediate needs of the client.

Response to technical difficulties
Should technical difficulties cause session disruption, Karen Hebert, LMFT, LPC will contact the client via preferred telephone contact. If the technical difficulties can be resolved quickly, the session will resume and the client will not experience a shortened session length. If the technical issues cannot be resolved in a timely manner, the session will be rescheduled for a time when functionality is restored. The client will be contacted by email or phone to develop a plan for continuation of the session.

Consent to Treatment
I, voluntarily, agree to receive Telemental Healthcare assessment, care, treatment, or services and authorize Karen Hebert, LMFT, LPC provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Karen Hebert at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Signature of Client _____ Date _____

Limits of Confidentiality

Information discussed in the therapy setting is held confidential and not shared without written permission except under the following conditions:

1. If the client threatens suicide.*
2. If the client threatens to harm another person.*
3. If I have reason to suspect that a minor is being abused: including, but not limited to physical abuse, sexual abuse and unjustifiable cruelty or unreasonable punishment.*
4. If I have reason to suspect that an elderly person over 65 years of age or a dependent adult is being abused.*
5. If I am ordered by the courts to break confidentiality to comply with legal requirements.
6. If I consult with other marriage & family therapists, social workers or psychologists in order to provide you with the best care and service.
7. If I have a written release from you, authorizing me to speak with a party you designate such as an insurance company representative, doctor, other healthcare provider, school or family member.

* State law mandates that mental health professionals need to consult with social services to report these situations to the appropriate agency designated to receive such report.

Having read and understood the above, I agree to these limits of confidentiality.

_____	_____
Name of Client	Name of Therapist
_____	_____
Signature of Client	Signature of Therapist
_____	_____
Date	Date

HIPPA Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I hereby acknowledge that I received a copy of Sweetwater Practice's "HIPAA Notice of Privacy Practices" written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand I can obtain this practice's current Notice on request.

Client Signature:_____ Date:_____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ Security Code: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Sweetwater Practice, LLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

Cancellations, Missed Appointments, and Collections Policy

Your appointment time has been reserved exclusively for you. If you must cancel your appointment, please do so as far ahead of time as possible. All cancellations must be made no less than 24 hours in advance of your scheduled appointment time. If the appointment is scheduled for Monday, it must be cancelled the previous Friday. This will allow adequate time to reschedule another client into that time slot. **If you do not cancel within the aforementioned 24 hour period, you will be responsible for payment of the full fee for the missed appointment.** Please be aware I do enforce this policy.

All unpaid balances **plus an additional 30% surcharge** will be sent to a collection agency for recovery after 60 days. Balances not paid to the collection agency 60 days after their initial billing will then be sent to the Credit Bureau and will appear on your credit report. **By signing this form, you are stating that you understand all of the policies listed and are agreeing to the release of your name to my collection agency if your bill is unpaid after 60 days.**

_____	_____
Name of Client	Name of Therapist
_____	_____
Signature of Client	Signature of Therapist
_____	_____
Date	Date

THE AMEN CLINIC QUESTIONNAIRE

For each item, please describe your experience today or in the past two weeks using the following scale:
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently

____ 1. Frequent feelings of nervousness or anxiety
____ 2. Panic attacks
____ 3. Avoidance of places due to fear of having an anxiety attack
____ 4. Symptoms of heightened muscle tension (sore muscles, headaches)
____ 5. Periods of heart pounding, nausea, or dizziness (not w/ exercise)
____ 6. Tendency to predict the worst
____ 7. Multiple, persistent fears or phobias (dying, doing something crazy)
____ 8. Conflict Avoidance
____ 9. Excessive fear of being judged or scrutinized by others
____ 10. Easily startled or tendency to freeze in intense situations
____ 11. Seemingly shy, timid, and easily embarrassed
____ 12. Bites fingernails or picks skin
____ Total number of questions with a score of 3 or 4 for questions 1- 12

____ 13. Persistent sad or empty mood
____ 14. Loss of interest or pleasure from activities that are normally fun
____ 15. Restlessness, irritability, or excessive crying
____ 16. Feelings of guilt, worthlessness, helplessness, hopelessness
____ 17. Sleeping too much or too little, or early morning waking
____ 18. Appetite changes/ weight loss or weight gain through overeating
____ 19. Decreased energy, fatigue, feeling "slowed down"
____ 20. Thoughts of death or suicide, or suicide attempts
____ 21. Difficulty concentrating, remembering, making decisions
____ 22. Physical symptoms; headaches, chronic pain, digestive problems
____ 23. Persistent negativity or low self esteem
____ 24. Persistent feeling of dissatisfaction or boredom
____ Total number of questions with a score of 3 or 4 for questions 13-24

____ 25. Excessive or senseless worrying
____ 26. Upset when things are out of place or don't go according to plan
____ 27. Tendency to be oppositional or argumentative
____ 28. Tendency to have repetitive negative or anxious thoughts
____ 29. Tendency toward compulsive behaviors
____ 30. Intense dislike of change
____ 31. Tendency to hold grudges
____ 32. Difficulty seeing options in situations
____ 33. Tendency to hold on to own opinion and not listen to others
____ 34. Needing to have things done a certain way or you become upset
____ 35. Others complain you worry too much
____ 36. Tendency to say no without first thinking about the question
____ Total number of questions with a score of 3 or 4 for questions 25-36

0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently

____ 37. Periods of abnormally happy, depressed or anxious mood
____ 38. Periods of decreased need for sleep, energetic on much less sleep
____ 39. Periods of grandiose thoughts and ideas (feeling very powerful)
____ 40. Periods of increased talking or pressured speech
____ 41. Periods of too many thoughts racing through your mind
____ 42. Periods of increased energy level
____ 43. Periods of poor judgment that leads to risk-taking behaviors
____ 44. Periods of inappropriate social behavior
____ 45. Periods of irritability or aggression
____ 46. Periods of delusional or psychotic thinking
____ Total number of questions with a score of 3 or 4 for questions 37 – 46

____ 47. Short fuse or periods of extreme irritability
____ 48. Periods of rage without being provoked
____ 49. Often misinterprets comments as negative when they are not
____ 50. Periods of spaciness or confusion
____ 51. Periods of panic or fear for no specific reason
____ 52. Visual or auditory changes (seeing shadows or hearing sounds)
____ 53. Frequent periods of déjà vu (feeling you've been somewhere before)
____ 54. Sensitivity or mild paranoia
____ 55. Headaches or abdominal pain or uncertain origin
____ 56. History of head injury or family history of violence/ explosiveness
____ 57. Dark thoughts, may be homicidal or suicidal
____ 58. Periods of forgetfulness or memory problems
____ Total number of questions with a score of 3 or 4 for questions 47- 58

____ 59. Trouble staying focused
____ 60. Spaciness or feeling like you're in a fog
____ 61. Overwhelmed by tasks of daily living
____ 62. Feels tired, sluggish, or slow moving
____ 63. Procrastination, failure to finish things
____ 64. Chronic boredom
____ 65. Loses things
____ 66. Easily distracted
____ 67. Forgetful
____ 68. Poor planning skills
____ 69. Difficulty expressing feelings
____ 70. Difficulty expressing empathy for others
____ Total number of questions with a score of 3 or 4 for questions 59-70

MODIFIED HCL-32 QUESTIONNAIRE

Please try to remember a period when you were in a "high" state. How did you feel then? Please check these statements even if you do not feel that way currently. Please put a check mark by each that have applied in the past or now.

	Description	
1	I need less sleep	
2	I feel more energetic and more active	
3	I am more self-confident	
4	I enjoy my work more	
5	I am more sociable (make more phone calls, go out more)	
6	I want to travel and/or do travel more	
7	I tend to drive faster or take more risks when driving	
8	I spend more money/too much money	
9	I take more risks in my daily life (in my work and/or other activities)	
10	I am physically more active (sport etc.)	
11	I plan more activities or projects.	
12	I have more ideas, I am more creative	
13	I am less shy or inhibited	
14	I wear more colorful and more extravagant clothes/make-up	
15	I want to meet or actually do meet more people	
16	I am more interested in sex, and/or have increased sexual desire	
17	I am more flirtatious and/or am more sexually active	
18	I talk more	
19	I think faster	
20	I make more jokes or puns when I am talking	
21	I am more easily distracted	
22	I engage in lots of new things	
23	My thoughts jump from topic to topic	
24	I do things more quickly and/or more easily	
25	I am more impatient and/or get irritable more easily	
26	I can be exhausting or irritating for others	
27	I get into more quarrels	
28	My mood is higher, more optimistic	
29	I drink more coffee	
30	I smoke more cigarettes	
31	I drink more alcohol	
32	I take more drugs (sedatives, anti-anxiety pills, stimulants	