PATH TO CHANGE, LLC
314 TRIBBLE GAP ROAD, SUITE B, CUMMING, GA 30040
WWW.PATHTOCHANGE.NET
770.615.6115

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

Welcome to **Path to Change, LLC**. We are very pleased that you selected our facility 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 **Path to Change, LLC**. 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 experience. 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.

Background Information, Theoretical Views, & Client Participation

Information regarding your therapist's educational background and experience may be found on our website under his or her name. Please feel free to view that information at ***www.pathtochange.net.***

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/group leader at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

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.

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 kept in a file stored in a locked cabinet in our locked office. 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. In the latter case, your therapist's license does provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. This state has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential.

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.

Structure and Cost of Sessions

Your therapist agrees to provide psychotherapy according to the following fee schedule, unless otherwise negotiated by you: $130-$155 per 45-50 minute initial session and $110-$135 for additional 45-50 minutes individual and family/couple sessions. If you require a shorter or longer session, it will be prorated based on your rate.

Doing psychotherapy by telephone is not ideal, and needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed as follows: $30 for 10-20 minutes; $55 for 20-30 minutes; full session rate for 35-50 minutes. The fee for each session will be due at the conclusion of the session.

As with telephone calls, you will be billed for time spent making reports taking greater than 10 minutes to other professionals including medical doctors and school officials. This will be at the above rate for telephone calls.

Therapists at *Path to Change, LLC* do not have training in forensic psychology, and therefore are not qualified to offer opinions for legal testimony. If my therapist is asked for any type of legal affidavit, or is subpoenaed for legal testimony to be given in writing or by being present in court, I understand that the cost for the therapist's time increases significantly, to $500/hour.

Cash, personal checks, Visa, MasterCard, or Discover are acceptable for payment, and we will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $30 fee for any returned checks.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. We are not in-network with insurance companies. We will be glad to provide you with a statement for your insurance company which you may submit toward out-of-network benefits.

Unpaid Balance: If you have an unpaid balance, no records, test results or evaluations will be released until the balance is paid in full.

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.

In Case of an Emergency

Path to Change, LLC is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we 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 or Lifeline at (800)273-8255 (National Crisis Line)
- Call Ridgeview Institute at 770.434.4567 or Peachford Hospital at 770.454.5589
- Call 911.

Please initial that you have read this page _____

- 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. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. 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.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients confidential. As much as your therapist would like to, for your confidentiality he or she will not address you in public unless you speak to him or her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Statement Regarding Ethics, Client Welfare & Safety

Path to Change, LLC assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. 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. If the two of you are unable to resolve your concern, please contact the center director.

Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

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:

Please initial that you have read this page _____

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 only for appointment confirmations (nothing that could be inferred as therapy). Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. If you do, please know that we cannot guarantee the confidentiality of this information. You also need to know that we are required to keep a summary or a copy of all emails and texts as part of your clinical record that address anything related to therapy. In addition, at your request, we will email you a copy of a superbill for insurance purposes.

Social Networking: It is our policy not to accept requests from any current or former clients on social networking sites because it may compromise your confidentiality. ***Path to Change, LLC*** has a business Facebook page. You are welcome to follow or "like" us. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to ***Path to Change, LLC***. Please refrain from making contact with us using social media messaging systems such as Facebook Messenger. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message.

Google, Bing, etc.: It is our policy not to search for our clients on Google or any other search engine. If there is content on the Internet that you would like to share with your therapist for therapeutic reasons, please print this material and bring it to your session.

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. Additionally, information that has been faxed may also remain in the hard drive of our fax machine. When our fax machine needs to be replaced, we will destroy the hard drive in a manner that makes future access to information on that device inaccessible.

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. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites and/or apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide and communicate to your therapist if you would like this information as adjunct to your treatment or if you prefer that your therapist does not make these recommendations.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that we are open to any thoughts you have.

Please initial that you have read this page _____

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.

_____	_____
Client Name (Please Print)	**Date**
_____	
Client Signature	

If Applicable:

_____	_____
Parent's or Legal Guardian's Signature	**Date**
_____	_____
Therapist's Signature	**Date**

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CHILD/ADOLESCENT INTAKE FORM

This form will enable us to gain a quicker understanding of your child and it will become a part of their confidential file. Please answer each question as completely as possible.

Date _____

PART 1 : CHILD/ADOLESCENT

Child's Name_____
First Middle Last

Address_____
City State Zip

Child's Phone _____School_____Grade_____

Birthdate_____Age_____Sex_____

Height_____ Weight_____ Email_____

Pediatrician/Primary Care Physician_____

Address_____Phone_____

Current Medications (list all, including vitamins and herbal supplements)_____
_____

Person completing this form_____

PART II : PARENTS

Mother's name_____Birthdate_____

Address (if different from Child) _____

Preferred phone_____ Email _____

Occupation_____Work phone_____

Father's name_____Birthdate_____

Address (if different from Child) _____

Preferred Phone_____ Email _____

Occupation_____Work phone_____

Parent's marital status: Married _____ Divorced _____ Separated _____
Never married _____ Remarried _____ How long? _____ Other _____
Date of Divorce _____ Date of Remarriage _____

PART III : FAMILY MEMBERS

List all people: Name/Age/Relationship to Child

_____

_____

_____

Who has legal custody? ❒ Mom ❒ Dad ❒ Joint ❒ Other _____

Who has physical custody? ❒ Mom ❒ Dad ❒ Joint ❒ Other _____

Stepparent's name_____ Birthdate_____

Home phone_____ Cell Phone_____

Stepparent's name_____ Birthdate_____

Home phone_____ Cell Phone_____

Who gave you our name? _____

May we have your permission to thank this person for your referral? ❒ Yes ❒ No

Religious Affiliation_____ Church_____

Parents : ❒ Active ❒ Inactive Child : ❒ Active ❒ Inactive

PART IV : FINANCIAL

If you have any financial questions or concerns about your fee, please talk to your therapist. Fees are due at the time of service. You may use cash, check, debit cards, Visa, MasterCard or Discover.

You will be required to pay the full cost of the session if you do not show up for your scheduled appointment **and you have not notified us at least 24 hours in advance.**

Who is financially responsible for these fees? _____

Signed_____ Date_____

PSYCHOSOCIAL HISTORY

PART V : DEVELOPMENT

Please fill in any information you have on the areas listed below.

❒ Prenatal medical illness _____

_____

❒ Premature Birth _____

❒ Birth Complications _____

Check any problems during first year of life :

❒ Allergies _____

❒ Sleep patterns or problems _____

❒ Any other medical problems _____

_____

❒ Developmental Issues _____

PART VI : HEALTH

Check any :

❒ Major childhood illness ❒ Hospitalizations ❒ Medications ❒ Allergies ❒ Head trauma

❒ Important accidents and injuries ❒ Surgeries ❒ Periods of loss of consciousness

❒ Convulsions/seizures ❒ Other medical conditions

Please list age and explanation below _____

_____

_____

Is your child currently taking any medications? ❒ Yes ❒ No If yes, please list _____

_____

Please list any special classes or therapies attended currently or in the past _____

_____

Have there been any previous psychological, psychiatric, neurological or EEG evaluation?

❒ Yes ❒ No If yes, list provider and dates of service _____

_____

Has child had any previous counseling? ❒ Yes ❒ No If yes, please list name of counselor and date of contact _____

PART VII : RESIDENCES

1. Homes – please list all dates that the child has lived in different residences, including location, who they were living with, their reason for moving, and any problems.

_____

_____

_____

2. Residential placements, institutional placements, or foster care–if applicable, please list dates that the child was placed in a home, the program and location, the reason for the placement, and any problems.

_____

_____

PART VIII : SCHOOL

Describe any difficulties in school (i.e. learning, friendships, bullying, anxiety, etc.)

_____

_____

PART IX : SPECIAL SKILLS OR TALENTS OF CHILD

List hobbies, sports, recreational interests, TV, and toy preferences, etc. _____

_____

Name 3 strengths and 3 weaknesses: _____

_____

_____

PART X : OTHER

Is there any else I should know that doesn't appear on this or any other forms, but might be important?

_____

_____

CONCERNS CHECKLIST

1. _____ Anger/Temper
2. _____ Depression
3. _____ Divorce/Separation of Parents
4. _____ Adjustment of Parent's Remarriage
5. _____ Physical of Sexual Abuse
6. _____ School Performance
7. _____ Family Problems
8. _____ Conflict with Siblings
9. _____ Fearfulness
10. _____ Physical Problems
11. _____ Physical with Social Relationships
12. _____ Sleep Problems
13. _____ Nightmares
14. _____ Sexual Concerns
15. _____ Religious/Spiritual Concerns
16. _____ Talk of Suicide
17. _____ Unhappy Most of the Time
18. _____ Use of Alcohol
19. _____ Use of Drugs
20. _____ Worry
21. _____ Self-Esteem
22. _____ Poor Appetite
23. _____ Over Eating
24. _____ Bedwetting
25. _____ Soiling
26. _____ Cruelty to Animals
27. _____ Fire Setting
28. _____ Problems with Concentration
29. _____ Grief/Death of a Loved One

Below you will find statements about your child and any symptoms he or she may be experiencing. Circle the number below the word that best describes your child's behavior during the last 3 months. Please write by the statement any additional information that you feel would be helpful.

		Never	Sometimes	Often	Always
1.	My child continually seeks attention.	0	1	2	3
2.	I can see tension building up in my child.	0	1	2	3
3.	My child explodes under stress.	0	1	2	3
4.	My child has nervous habits, like pulling at his/her clothing, clearing his/her throat, sniffing his/her nose, etc.	0	1	2	3
5.	My child cries easily.	0	1	2	3
6.	My child sucks his/her thumb or finger.	0	1	2	3
7.	My child rocks back and forth.	0	1	2	3
8.	My child shakes and trembles.	0	1	2	3
9.	My child is moody.	0	1	2	3
10.	My child becomes overexcited easily.	0	1	2	3
11.	My child is hyperactive and restless.	0	1	2	3
12.	My child becomes hysterical, upset, or angry when things do not go his/her way.	0	1	2	3
13.	My child seems sad.	0	1	2	3
14.	My child walks or talks in his/her sleep.	0	1	2	3
15.	My child gets confused easily.	0	1	2	3
16.	My child has trouble remembering things.	0	1	2	3
17.	My child complains he/she never gets a fair share of things.	0	1	2	3
18.	My child says people don't like him/her.	0	1	2	3
19.	My child tends to be very selfish and self-centered.	0	1	2	3
20.	My child is very shy.	0	1	2	3
21.	My child is sensitive and has his/her feelings hurt easily.	0	1	2	3
22.	My child avoids competition.	0	1	2	3
23.	My child is a poor sport and a poor loser.	0	1	2	3
24.	My child has trouble making friends.	0	1	2	3
25.	My child seems to have little self-confidence.	0	1	2	3
26.	My child cannot get along with my husband/wife.	0	1	2	3
27.	There is a lot of arguing and fighting in our house.	0	1	2	3

		Never	Sometimes	Often	Always
28.	My child expresses concerns about something terrible or horrible happening to family members or himself/herself.	0	1	2	3
29.	My child expresses strong dislike for home and family.	0	1	2	3
30.	One (or more) of my children has problems, also.	0	1	2	3
31.	My child says strange things or asks unusual questions.	0	1	2	3
32.	My child does strange things.	0	1	2	3
33.	My child often has small accidents or injuries.	0	1	2	3
34.	My child is a discipline problem at home.	0	1	2	3
35.	My child is a discipline problem at school.	0	1	2	3
36.	My child tells tall tales or lies.	0	1	2	3
37.	My child often throws temper tantrums.	0	1	2	3
38.	My child has attempted to seriously harm a person or animal.	0	1	2	3
39.	My child manipulates situations to his/her own benefit.	0	1	2	3
40.	My child does sexual things he/she shouldn't.	0	1	2	3
41.	My child seems to welcome punishment.	0	1	2	3
42.	My child disturbs other children by teasing, provoking fights, and interrupting others.	0	1	2	3
43.	My child steals things.	0	1	2	3
44.	I have to spank my child.	0	1	2	3
45.	My child voices an intense dislike of school.	0	1	2	3
46.	My child does not seem to be learning as he/she should.	0	1	2	3
47.	The teachers complain about my child.	0	1	2	3
48.	My child stares blankly into space and is unaware of his/her surroundings when doing so.	0	1	2	3
49.	My child often complains of illnesses such as nausea, stomach pain or headaches.	0	1	2	3

Please circle YES or NO to the following states as it pertains to your child.

50. My child's bowels move regularly. YES NO
51. My child is overweight. YES NO
52. My child is underweight. YES NO
53. My child is in a special program at school. YES NO
54. My child may have a learning disability. YES NO
55. My child has a visual, hearing, or speech problem. YES NO
56. My child has a chronic illness or handicap. YES NO