Tracy R. Limes, MA, LPC
317 Creekstone Ridge
Woodstock, GA 30188
770.605.9543

Couple Intake Information

The purpose of the following questionnaire is to help me to understand some important things about you and your spouse so that we may help you most effectively. Please complete these forms as fully as possible.

Your Information

Name_____ Date_____
(Last) (First) (Middle)

Address_____

City_____ County_____ ZIP Code_____

Phone (H)_____ (W)_____ Other_____

E-mail _____

Emergency Contact_____
(Name) (Address) (Phone)

Birth Date_____ Age_____

Education & Degree (if applicable)_____

Name of church you attend (if applicable)_____

Occupation_____ Employer_____

Spouse Information

Name_____ Date_____
(Last) (First) (Middle)

Address_____

City_____ County_____ ZIP Code_____

Phone (H)_____ (W)_____ Other_____

E-mail_____

Emergency Contact_____
(Name) (Address) (Phone)

Birth Date_____ Age_____

Education & Degree (if applicable)_____

Name of church you attend (if applicable)_____

Occupation_____ Employer_____

How did you here about Tracy?_____

Couples Intake Information (continued)

Marital History

Date married _____ Number of years married _____

Your age when married _____Spouse's age when married _____

Previous marriages (indicate number of years married and any children resulting from that marriage) :

Yourself: _____

Spouse: _____

Please list the names and ages of all who live in your home:

Names	Ages	Indicate where they live
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Describe your family's relationship with one another growing up. (Ex: How did your parents get along, how did you and your siblings get along?)

Yourself: _____

_____

Spouse: _____

_____

Discuss your current relationship with your parents.

Yourself: _____

Spouse: _____

Please list your brothers, sisters, and yourself in birth order starting with the oldest. Give their ages. Be sure to include yourself by indicating "me."

<u>Yourself</u>

Names	Ages
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Couples Intake Information (continued)

Spouse

Names Ages

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Does someone in your family have a substance abuse problem?

Yourself: _____

Spouse: _____

Has someone in your family ever received counseling or psychiatric diagnosis?

Yourself: _____

Spouse: _____

Have you or a family member ever experienced domestic violence?

Yourself: _____

Spouse: _____

Client History

Referred by_____ Address_____

Have you ever received counseling before? Yes_____ No_____

If so, list counselor(s) and dates: _____

Has your spouse ever received counseling before? Yes_____ No_____

If so, list counselor(s) and dates: _____

What was helpful? _____

_____

Have you had any major losses or traumatic experiences in your life?

Yourself: _____

Spouse: _____

Couples Intake Information (continued)

List any major health problems for which you or your spouse are currently receiving treatment:

Yourself: _____

Spouse: _____

List any medications (including dosages) you or your spouse are currently taking:

Yourself: _____

Spouse: _____

Briefly describe the problem for which you are seeking help:

_____

_____

_____

_____

_____

_____

Couples Intake Information (continued)

Please complete the following statements:

1 I worry about

2 I am happiest when

3 What I do best is

4 I have been criticized for

5 I sometimes feel guilty about

6 It makes me angry when

7 My biggest mistake was

8 My hobby is

9 It makes me nervous when

10 My experience with religion

11 My personality would be better if

12 I often felt mother was

13 My childhood was

14 My biggest disappointment

15 I would be better liked if

16 To me sex is

17 Men seem to be

18 I often felt father was

19 An unspoken fear I have is

20 Women seem to be

21 What hurts me most is

22 In relationships, I don't seem to be able to

23 To me intimacy is

24 Lately I have been feeling

25 My spouse is

Spouse – Please complete the following statements:

1 I worry about

2 I am happiest when

3 What I do best is

4 I have been criticized for

5 I sometimes feel guilty about

6 It makes me angry when

7 My biggest mistake was

8 My hobby is

9 It makes me nervous when

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20 Women seem to be

21 What hurts me most is

22 In relationships, I don't seem to be able to

23 To me intimacy is

24 Lately I have been feeling

25 My spouse is

Policies

Confidentiality: A very important aspect of developing the openness, honesty, and trust between counselor and client is confidentiality. Whatever you share with me will be kept in the strictest confidence and will not be disclosed to anyone without your express, written consent. At the same time, it is important for you to know that, under Georgia law, a few situations sometimes arise in which I am both legally and ethically required to make disclosures that are necessary to ensure the safety of yourself or others. Those situations include:

Child abuse
Threat of physical violence to others
Suicidal intent

I will further discuss any aspect of confidentiality, which may concern you, including any information requested by your insurance company. **Initial:_____**

Court: I do not participate in divorce or child custody proceedings because the same professional should not perform evaluation and therapy. Under the circumstances that I am subpoenaed to appear in court or have to put together a sworn affidavit, **I will bill at $200 an hour for all time (consultation, phone calls, emails, texts, travel time, etc.) spent on the case.**
Initial:_____

Emergencies: If you have an emergency (something that cannot wait for your next appointment), please call me at 770.605.9543. All calls are returned within 24 hours or the next business day. If you feel that you cannot wait, please call 911 or go to the nearest Hospital Emergency Room for help. **Initial:_____**

Insurance: Since each Insurance Company is different in the health benefits it provides, there can be no guarantee that the counseling services you receive will be covered. Although I am a qualified and licensed professional, exact requirements for payment vary. You should be able to ascertain your plan's eligibility from your agent, your insurance company, or your employer. In the event that your insurance company requires correspondence with me in order to reimburse you for services provided by me, you will be asked to provide specific written consent so that I can communicate with your insurance company.
Initial:_____

Cancellation Policy: Payment in full is due when services are rendered unless other arrangements have been made with your counselor in advance. For cancellations occurring at least 24 hours prior to your appointment time, no charges will be incurred. For cancellations occurring less than 24 hours in prior to your appointment time, the full charge for your scheduled session will be applied. For appointments not kept (and not cancelled) the full amount will be charged. For those who are on a sliding scale, the full rate (not the sliding scale rate) will be charged. **Initial:_____**

Please sign below, indicating that you have read and received a copy of this information.

Client Signature_____ Date_____

Keep This Copy For Your Records

Confidentiality: A very important aspect of developing the openness, honesty, and trust between counselor and client is confidentiality. Whatever you share with your counselor will be kept in the strictest confidence and will not be disclosed to anyone without your express, written consent. At the same time, it is important for you to know that, under Georgia law, a few situations sometimes arise in which I am both legally and ethically required to make disclosures that are necessary to ensure the safety of yourself or others. Those situations include:

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Please sign below and keep the two subsequent pages of information for your records.

Georgia Notice Form

By signing below, I am acknowledging that I have received a copy of the Georgia Notice Form concerning the policies and practices protecting my health information.

Signed_____ Date_____

Georgia Notice Form

Notice of Licensed Professional Counselor Policies and Practices
to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Heath Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment" is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as family physician or another psychologist.
- "Payment" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health care insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- "Health Care Operations" are activities that relate to the performance and operation of my practice, Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides that insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse - If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

- Adult and Domestic Abuse - If I have reasonable cause to believe that a disabled adult or elder person has had physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

- Health Oversight Activities - If I am the subject of an inquiry by the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.

- Judicial and Administrative Proceedings - If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order.

- Serious Threat to Health or Safety - If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

- Workers Compensation - I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Licensed Counselor's Duties

Patient's Rights:

- Right to Request Restrictions - you have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction that you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations -- You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy -- You have the right to inspect and/or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss the details of the request and denial process.
- Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Licensed Counselor's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will inform you of that change in a session or on the phone, and that information may be also provided to you in written form while you are in a session or through the mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please inform me. You may also contact the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, I will promptly distribute the revised Notice, post it in the waiting area of my office, and make copies available to my patients.