



Teri Cress, M.A., LAPC, LAMFT  
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404-555265

## CLIENT INFORMATION AND COUNSELING AGREEMENT

**Client confidentiality is an essential part of the psychotherapy process.** Ordinarily, information you share will not be given to anyone without your informed written consent. However, exceptions include: (1) when, in my judgment, a client appears an imminent danger to him/herself or others, (2) when a minor appears endangered by abuse/neglect of a caregiver, (3) when I consult with a colleague (without sharing your identifying information), (4) when records for a client are subpoenaed by a court of law.

**I prefer phone voicemail over email.** Not only is email not completely confidential, I am generally much faster at phone communication. While I always attempt to return calls within 12-24 hours, it sometimes may take me days to return an email. Voicemail is best.

**Please limit between-session phone calls as much as possible.** You may call my voice mail and I will return the call as soon as possible; however, as I do not carry a pager and am not available 24 hours a day, several hours may pass before I am able to return the call. If you have an emergency, you should call 911 or go to the nearest hospital or emergency room.

**Payment will be collected at the beginning of each session.** This allows us to end sessions on time and remain focused on the issues being addressed as we complete our time together. *All checks should be made out to "Restored Hearts"*

**There may be a \$15 charge for all returned checks.** I hope no one will ever have to pay this fee.

**All sessions are based upon a 50-minute therapeutic hour.** The space between clients allows me to write notes and adequately prepare for my next client. If I am running late, I will ensure you receive your full 50-minute session; however, sessions will end on time for clients who arrive late. On-time arrival is the best way to ensure you receive a full session.

**Please remain seated in the lobby until I come to get you.** I often see clients each hour and am likely seeing someone else just prior to your appointment. Remaining in the lobby helps to ensure your confidentiality as well as that of my other clients.

In signing below, I understand the above stated policies as conditions of my counseling agreement.

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**Client Signature (Parent/Guardian signature if under age 18)      Date**



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## CLIENT INFORMATION QUESTIONNAIRE

Your cooperation in completing this questionnaire will be helpful in planning our time together. Please answer each item as carefully and completely as possible. If needed, feel free to ask for clarification during the session. For couples: each person must complete a separate intake form. For parents of minor children: seeking counseling, please complete this form with your child's information and sign as "parent or guardian".

### DEMOGRAPHIC INFORMATION (Please print)

Today's Date: \_\_\_\_\_

Client's Full Name \_\_\_\_\_  
(Last) (First) (Middle Initial)

Mailing Address: \_\_\_\_\_  
(City) (State) (Zip)

Email Address: \_\_\_\_\_ May I email you?  Yes  No  
*\*Please be aware that email might not be a confidential form of communication.*

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ May we leave a message?  Yes  No  
Work (\_\_\_\_\_) \_\_\_\_\_ May we leave a message?  Yes  No  
Cell (\_\_\_\_\_) \_\_\_\_\_ May we leave a message?  Yes  No

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender:  Male  Female

Marital Status:  Never Married  Married  Separated  Divorced  Widowed  Other

If married, spouse's name and age: \_\_\_\_\_

### Marital/relationship history

Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when ended
First _____			
Second _____			
Third _____			

**Children** (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

**Family-of-origin history**

Relative	Name	Current age (or age at death)	Illness (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Stepparent					
Brothers					
Sisters					

**Briefly describe why you are seeking counseling at this time:**

**OCCUPATIONAL INFORMATION**

**1. Highest level of education completed:**  Some high school     GED     Some college  
 Associate     Bachelors     Masters     Doctorate     Other: \_\_\_\_\_

**2. Are you currently employed?**  Yes     No  
If yes, list your occupation and your current employer:

If yes, how happy are you in your current position: \_\_\_\_\_

3. Your family's approximate gross annual income: \$ \_\_\_\_\_ (if relevant)

PERSONAL HEALTH AND SOCIAL INFORMATION

1. Overall, how is your physical health at present? (please circle)

Poor                      Unsatisfactory                      Satisfactory                      Good                      Very Good

2. Please list any current and/or persistent physical symptoms or health concerns:

\_\_\_\_\_  
\_\_\_\_\_

3. List all significant health problems and initial dates of diagnoses:

\_\_\_\_\_  
\_\_\_\_\_

4. List all current medications and dosages (including over-the-counter and naturopathic):

Medication Name                      Dosage Prescribed                      Dosage Generally Taken (if different)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Client's Primary Physician: \_\_\_\_\_ Date Last seen \_\_\_\_\_

6. Are you currently or have you previously received psychiatric (medical) or psychological (counseling) assistance?  Yes     No

If yes, please explain when and with whom for all current and previous assistance: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

7. Are you having any problems with your sleep habits?  No     Yes (check all applicable)

Sleeping too little (avg. amount): \_\_\_\_\_  Poor quality sleep

Sleeping too much (avg. amount): \_\_\_\_\_  Disturbing dreams

Early morning wakening (avg. wake time): \_\_\_\_\_  Difficulty getting to sleep

Other \_\_\_\_\_

**8. How many times per week do you exercise?** \_\_\_\_\_ Approx. how long each time? \_\_\_\_\_

**9. Are you having any difficulty with appetite or eating habits?**  Yes  No

If yes, circle all applicable:  Eating less  Eating more  Binging  Restricting

Have you experienced significant weight change in the last 2 months?  Loss  Gain  Neither

**10. Describe your typical alcohol consumption:**  I do not drink

Weekdays (daily average):

\_\_\_\_\_

Weekends (daily average):

\_\_\_\_\_

**11. Do you regularly smoke tobacco?**  Yes  No

If yes, daily average usage:

\_\_\_\_\_

**12. How often do you engage in recreational drug use?**  Daily  Weekly  Monthly  Rarely

Never

Which drugs (street and/or prescription?) \_\_\_\_\_

**13. Have you had suicidal thoughts recently?**  Frequently  Sometimes  Rarely  Never

Have you had them in the past?  Frequently  Sometimes  Rarely  Never

**14. In the past year, have you experienced any significant life changes or stressors?**  Yes

No

If yes, please explain: \_\_\_\_\_

**Which of the following problems have impacted you (check all that apply):**

	Past 1 month	Past 6 months	Before 6 months ago	Never
Alcohol/substance abuse				
Anger outbursts				
Anxiety				
Appetite changes				
Appetite changes				
Body complaints				
Body image				
Concentration				
Decision making				
Depressed mood				
Digestive/bowel troubles				
Disturbing thoughts				

Eating disorder				
Fears				
Financial				
Friendships				
Hallucinations				
Headaches				
Homicidal thoughts				
Legal problems				
Loneliness				
Low energy				
Marital (non-sexual)				
Marital (sexual)				
Marital divorce				
Marital separation				
Nightmares				
Pain (explained)				
Pain (unexplained)				
Panic attacks				
Parenting issues				
Phobias				
Rapid speech				
Repetitive behaviors ( <i>e.g. frequent checking</i> )				
Repetitive thoughts ( <i>e.g. obsessions</i> )				
Sexual compulsivity				
Sleep disturbances				
Suicidal thoughts				
Suicide attempt				
Tiredness/lethargy				
Losses of time				
Memory lapses				
Weight change (unwanted)				
Mood swings (significant)				

**RELIGIOUS/SPIRITUAL INFORMATION**

Do you consider your faith/religion meaningful in your life currently?    Yes    No

If yes, what is your faith and church affiliation? \_\_\_\_\_

What does spiritual mean to you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**How did you hear about *Restored Hearts Counseling*?** \_\_\_\_\_

If you were referred by a professional, may we contact them to express our appreciation?  Yes    No

If yes, please provide name, telephone number (if known) \_\_\_\_\_



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## **INFORMED CONSENT FOR SPECIAL CIRCUMSTANCES:**

### **COUPLES THERAPY**

The purpose of couples therapy is for clarification, reconciliation, and healing and therefore is at cross-purposes, at times, with legal action that is adversarial by definition. In these cases, **no information** may be released for either party without written consent of both parties because, technically, the couple relationship itself *is* the client. This agreement makes any and all information from the therapy available to both parties of a legal dispute; therefore, I find it in the best interest of the therapeutic process for both parties to agree not to subpoena the therapist for either side in the event of a divorce or custody trial.

In addition, information received from either party via phone calls, voice mail, and/or written communication will not generally be kept secret because to keep such information secret would impede the therapeutic process and relationship.

I agree not to subpoena therapy records in the event of a legal proceeding.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

### **FAMILY THERAPY**

In family therapy, the family is the client. No information may be released without the consent of all parties to whom confidentiality belongs. As outlined in the couples' therapy section (above), I find it in the best interest of the therapeutic process for all parties to agree not to subpoena the therapist in the event of a legal proceeding.

In addition, information received from either party via phone calls, voice mail, and/or written communication will not generally be kept secret because to keep such information secret would impede the therapeutic process and relationship.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

## **GEORGIA NOTICE FORM**

### **Notice of Counselor's 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 Health 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, Payment and Health Care Operations*”
  - *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 your 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 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, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of my [office, clinic, practice group, etc.], 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 the 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 a 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 Psychological 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. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *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.
- *Worker's 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 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 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 or obtain a copy (or both) 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 with you 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.

##### 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 make available such revisions on the first session after changes are implemented.

## **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, you may contact Dr. C. Jeffrey Terrell at (404) 323-0734.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The department listed above can provide you with the appropriate address upon request.

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

This notice went into effect on April 15, 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. I will provide you with a revised notice by telephone or email contact.

**I have read the above information and voluntarily request counseling services at Restored Hearts Counseling, and I agree with these terms and conditions**

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## COUNSELING AGREEMENT AND CANCELLATION POLICY

**PLEASE READ AND SIGN THE FOLLOWING COUNSELING AGREEMENT AND CANCELLATION POLICY. IF THE CLIENT IS UNDER 18 YEARS OF AGE, THE AGREEMENT MUST BE SIGNED BY THEIR PARENT OR GUARDIAN.**

### **Counseling Agreement**

I understand that I am entering into a confidential therapeutic counseling relationship. I understand that I have the right to terminate this relationship upon due notice to my counselor.

I also understand that all fees, as outlined on the separate attached and signed sheet, are due at the time services are rendered unless previous arrangements have been made.

I understand that information concerning my counseling cannot be divulged to other parties without my prior written consent unless directed by Georgia Law. Other conditions of confidentiality will be discussed during the initial session.

### **Cancellation Policy**

If I fail to cancel a scheduled appointment, I understand that Teri Cress cannot use this time for another client who likely could have used the time effectively.

I further understand that there may be a \$50 charge for each hour appointment slot that is either missed or cancelled with less than 24 hours notice (unless due to illness or family emergency).

I understand this Counseling Agreement and Cancellation Policy covers me and any minor children I may include in counseling.

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Parent/Guardian signature if under age 18)



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## CURRENT FEE SCHEDULE

**PLEASE READ AND SIGN THE CURRENT FEE SCHEDULE PRIOR TO THE FIRST SESSION. IF THE CLIENT IS UNDER 18 YEARS OF AGE, THE AGREEMENT MUST BE SIGNED BY THE PARENT/GUARDIAN.**

Below is the current Restored Hearts fee schedule:

50-minute initial diagnostic interview \$100.00  
50-minute individual session 100.00  
50-minute joint marital session 100.00  
Court depositions/testimony per hour (door to door) 250.00  
Missed sessions (or cancelled within 24 hours) 50.00

### **Sliding Fee schedule**

Restored Hearts offers a sliding fee scale based on income and the number of family members. If there is a financial hardship please don't hesitate to ask about this. I would never want someone in need to not get help due to finances.

If you believe your insurance company may reimburse you for your visits, please mention this during our intake session. I will be happy to provide you with receipts to assist you in gaining reimbursement. Restored Hearts does not accept assignment; therefore, *payment of all fees is the responsibility of the individual signed below at the time services are rendered.*

I have read the above fee schedule (including the 24-hour cancellation policy) and agree to its terms and conditions. By signing this agreement, I accept responsibility to pay these fees as services are rendered. I also understand I have the right to a copy of this agreement upon request.

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**Signature of Person Responsible for Payment**

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**Date**

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**Printed Name of Above Individual**