A.T.L. PSYCHOTHERAPY
& CONSULTING SERVICES
Sandtown Professional Park
5835 Campbellton Rd. SW, suite 102
ATLANTA, GA 30331
(404) 941-7326 (office) (404) 941-7556 (fax)

Adult Intake Form

Today's Date

Identifying Information		
Full name		
Date of Birth:		Age:
Home Address:		
Cell phone number:		
Home phone number:		
Email Address:		
Disability Status:		
Gender Identity:		
Sexual Orientation:		
Racial/ethnic identities:		
Birthplace (country/state):		
Religious/spiritual traditions or identity:		
Relationship Status: ☐Single ☐Committed Rel. ☐Married ☐Separated ☐Divorced ☐Widowed		
Highest Degree Earned		
School/College:		

Other ways you identify yourself that you consider important:	

Service you are requesting:

☐Individual Therapy ☐Couples Therapy ☐Family Therapy ☐Group Therapy

If some kind of emergency arises and we need to reach someone close to you, whom should we call?

Name:	Relationship:
Phone:	
Address:	

Client History

Please list everyone in your household and their relationship to you:

Name	Age	Gender	Live at home	Relationship

Please briefly describe concerns or problems that bring you to therapy at this time:

Please check the box beside any of the following areas of concern, either past or present:

☐Alcohol/Drug Abuse	☐Hopelessness	☐Paranoia	☐Anger Control
☐Homicidal Thoughts	☐Parenting Concerns	☐Anxiety	☐Hostility

☐Phobias/Panic	☐Assertiveness	☐Isolation	☐School
☐Attention/Concentration	☐Impulse Control Problems	☐Bereavement/Grief	☐Self-Defeating
☐Insomnia	☐Self Esteem Issues	☐Communication	☐Irritability
☐Self-Injurious Behaviors	☐Depression	☐Identity Issues	☐Sexual Abuse
☐Work Problems	☐Legal Issues	☐Sexuality	☐Spirituality
☐Domestic Violence	☐Marital/Relationship Issues	☐Stress	☐Eating/Food
☐Medical Concerns	☐Suicidal Thoughts	☐Memory	☐Family

Have you been to counseling or therapy before? ☐Yes ☐No

Date:

Nature of Problem:

Therapist:

Benefit from therapy?

Current medications:

Medication	Dosage	Reason for Use	Prescribing Physician

Please describe use of alcohol, tobacco, or other substances:	
Substance	Frequency of Use

Please describe any trauma you may have experienced (i.e. severe car accident, death of a loved one/pet, abuse, natural disaster):	
Description of trauma	Age/Year

Please list anyone in your family who has been to therapy or diagnosed with any type of mental illness:		
Relationship to you	Problem	Nature of treatment, if any

Medical Concerns:	
Primary Physician	Date of Last Visit
Please list any other information you would like me to know:	

Referral Information
Referred by:
Do we have permission to thank your referral source? ☐Yes ☐No

Confidentiality

In general, the privacy of all communications between a patient and psychologist is protected by law, and your therapist can only release information about your work to others with your written permission. However, there are a few exceptions. If your therapist has reason to believe that a child, elderly person, or disabled person is being abused, they must file a report with the appropriate state agency. If your therapist becomes aware of an immediate threat of harm to a particular individual, they would be required to take protective actions that might include notifying the potential victim, contacting the police, contacting family members, or seeking hospitalizations. If a patient threatens to harm himself/herself, your therapist may be obligated to seek hospitalizations for him/her to contact family members or others who can provide protection. These situations have rarely occurred in our practice. If a similar situation occurs, your therapist will make every effort to fully discuss it with you before taking any action.

Your therapist may also occasionally find it helpful or even necessary to consult other professionals about your case. During a consultation, every effort will be made to avoid revealing your identity. The consultant is also legally bound to keep the information confidential. If you do not object, you will not be told about these consultations unless your therapist feels it is important to your work together. The laws and standards of the psychological profession require that treatment records are kept. You are entitled to receive a copy of your records, or your therapist can prepare a summary for you. However, since these are professional records, they can be misinterpreted by untrained readers. If you wish to see your records, we recommend that you review then in your therapist's presence so that they can discuss the contents with you. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

Records can be released to a third party with your written consent. This might include for example, release of information to another treatment provider or an insurance carrier per your request. Please note, however, that your therapist cannot be responsible for the confidentiality of disposition of records released to a third party once in the hands of that third party. Once you are given a copy of your report, you are responsible for its confidentiality. You will need to be careful of who receives a copy of the report and explore how they will use and store the information provided. You are encouraged to keep the report in a safe place to ensure its protection and privacy. If you do not sign this form agreeing to our privacy practices, we cannot treat you, because we need to use you PHI to evaluate, diagnose, and treat you.

Contacting Therapist

Our telephone number is (404) 941-7326 and our email address is atlinfo@atlpsychology.com. Although your therapist is not immediately available to take calls, you are welcome to schedule a brief phone consultation to discuss the issue(s) you may have. Email is always the best form of communication. Your therapist will make every effort to return your email within 48 hours, with the exception of weekends and holidays. If your therapist is out of the office for extended time, they will leave the name of a colleague who may be contacted if necessary.

In an emergency, you can try to contact your therapist at out office number. If you are unable to reach your therapist and feel that you cannot wait for a return call or email, please call 911 or go to your local emergency room and ask for the physician on call.

I have thoroughly read over the confidentiality and contact information.

_____

Signature of client or personal representative

I have completed these forms to the best of my ability

_____

Signature of client or personal representative

Paperwork Fee Policy

We require a minimum of three office visits prior to any paperwork being filled out for clients. This includes, but is not limited to, FMLA, SSI disability, and treatment progress reports. There will be a **$25.00 fee** at the time of the request for forms to be filled out and completed.

*Please note that all requests will have a two-week turnaround time.

_____

Responsible Party- Print name

_____

Responsible Party- Signature

_____

Date

Credit Card Authorization

I authorize **ATL Psychotherapy & Consulting Services** to charge my credit card for services rendered, no show fees, and late cancellation fees. This information is stored in a secure system. This information will be destroyed upon termination of counseling and balance is paid in full.

_____

Responsible Party- Signature

_____

Date

Authorization for Release of Information

Client's Name _____
Date of Birth:_____

I hereby authorize **ATL Psychotherapy & Consulting Services** to release, obtain, or exchange information about my psychological treatment, either verbally or in writing, to the following agency or individual:

Name: _____
Address:_____
_____
Phone: _____ Fax: _____

Such information may include records of my psychological evaluation and treatment. The purpose of this release is:

I acknowledge that this release may be revoked in writing at any time, and that otherwise it is valid until termination of treatment.

I hereby release ATL Psychotherapy & Consulting Services from any and all liabilities, responsibilities, damages, claims, or legal actions that might arise from the release of the information authorized above. I also release ATL Psychotherapy & Consulting Services from liability or responsibility for the disposition of these records once in the hands of the person or agency named above.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

This information is released specifically to you from records that are legally protected. You are prohibited from further releasing this information to any other party without specific written consent of the person to whom it pertains. The use and disclosure of information contained in this record is restricted by the Health Insurance Portability and Accountability Act of 1996 and is protected under the Privacy Act of 1974.

_____ _____
Signature of Client (or legal guardian) Date