PREMIER COUNSELING SERVICES
318 S Welborn Street, Suite C • Hinesville, Georgia 31313
Phone (912) 332-5145 • Fax (912) 332-5153

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. **COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Premier Counseling Services has put in place preventative measures to reduce the spread of COVID-19; however, Premier Counseling Services **cannot guarantee** that you or your child(ren) will not become infected with COVID-19. Further, attending face-to-face therapy sessions **could increase** your risk and your child(ren)'s risk of contracting COVID-19.

****

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending face-to-face counseling sessions and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Premier Counseling Services may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Premier Counseling Services employees, volunteers, and program participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at Premier Counseling Services or participation in Premier Counseling Services programming ("Claims").

On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, and hold harmless Premier Counseling Services, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Premier Counseling Services, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any Premier Counseling Services program.

Client Name: _____ Date: _____

Name of Parent/Guardian: _____

Signature of Client/Parent/Guardian: _____

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CONSENT TO TREATMENT

This form is to document that I, _____ am requesting counseling/treatment services from *Premier Counseling Services*.

- **I also understand that while in counseling/treatment, and as a result of the dynamics involved in counseling/treatment, I may experience and feel emotional strain, feel worse during counseling/treatment, and make lifestyle changes that could be distressing.**
- **I also understand that in order to receive the maximum benefits from counseling/treatment, regular attendance and participation is crucial for positive outcomes.**
- **I understand that I am free to discontinue counseling/treatment at any time. If I decide to do so I will notify *Premier Counseling Services* or their representative in write, by telephone, or in person, at least two (2) weeks in advance so that effective planning for continued care (if needed) can be implemented.**
- **I understand that all communication with *Premier Counseling Services* is confidential except in matters where there may be imminent danger to harm myself or others.**
- **I understand that exceptions to this rule must be approved by me and I must give that approval by signing a consent form.**
- **I also understand, by law, that *Premier Counseling Services* must report all suspected or actual domestic violence, child abuse or elder abuse incidents to the appropriate authorities (i.e. DFCS, police).**
- **I also agree to pay directly for services provided by *Premier Counseling Services*, or comply with my insurance provider protocol for remuneration and fees.**

_____	_____	_____
Name of Client	**Client Signature**	**Date**
_____	_____	_____
Name of Parent/Guardian	**Parent/Guardian Signature**	**Date**
_____	_____	_____
Name of Witness	**Witness Signature**	**Date**

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INFORMED CONSENT

LEGAL ISSUES

1. INTERACTION WITH THE LEGAL SYSTEM

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system.

In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record, and I will be responsible for charges in producing that record.

If I believe it necessary to subpoena my therapist to testify at a deposition or a hearing, I would be responsible for his/her expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day would be billed at the rate of $375.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

CLIENT PRINTED NAME: _____

CLIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

Communication Addendum to the Informed Consent Agreement

Secure and private communication cannot be fully assured utilizing cell/smart phone or regular email technologies. It is the client's right to determine whether communication using non-secure technologies may be permitted and under what circumstances. Use of any non-secure technologies to contact Premier Counseling Services will be considered to imply consent to return messages to client via the same non-secure technology, pending further clarification from client.

Please check below which **modes** of communication **are permitted** and which **are not permitted**. This consent may be altered at any time should circumstances or preferences change.

In the event the client chooses not to allow non-secure modes of communication, contact will only be made via wire to wire phone (landlines), wire to wire fax, or mail (USPS).

Voice communication to client's cell phone for:

Scheduling appointments	___ Permitted	___ Not permitted
Appointment reminders	___ Permitted	___ Not permitted
Between session contact	___ Permitted	___ Not permitted

Voice communication from Premier Counseling Services' cell phone for:

Scheduling appointments	___ Permitted	___ Not permitted
Appointment reminders	___ Permitted	___ Not permitted
Between session contact	___ Permitted	___ Not permitted

Fax communication to client's non-secure fax or E-fax for:

Scheduling appointments	___ Permitted	___ Not permitted
Appointment reminders	___ Permitted	___ Not permitted
Between session contact	___ Permitted	___ Not permitted

If permitted, list permitted fax number(s):_____

Text communication to client's cell phone for:

Scheduling appointments	___Permitted	___Not permitted
Appointment reminders	___Permitted	___Not permitted
Between session contact	___Permitted	___Not permitted

Text communication from Premier Counseling Services' cell phone:

Scheduling appointments	___Permitted	___Not permitted
Appointment reminders	___Permitted	___Not permitted
Between session contact	___Permitted	___Not permitted

Contact via the client's email:

Scheduling appointments ___ Permitted ___ Not permitted

Appointment reminders ___ Permitted ___ Not permitted

Between session contact ___ Permitted ___ Not permitted

If permitted, list permitted email address(es):_____

Teleconferencing based communication to client's portal for:

Scheduling appointments ___ Permitted ___ Not permitted

Appointment reminders ___ Permitted ___ Not permitted

Between session contact ___ Permitted ___ Not permitted

If permitted, list permitted portal site(s):_____

Teleconferencing based communication from Premier Counseling Services' portal for:

Scheduling appointments ___ Permitted ___ Not permitted

Appointment reminders ___ Permitted ___ Not permitted

Between session contact ___ Permitted ___ Not permitted

If permitted, list permitted portal site(s):_____

Statement of Validation.

I have read this Communication Addendum to the Informed Consent Agreement, it has been adequately explained to me, and I understand its contents.

By Client(s):

_____	_____	_____
Print Name Here	**Sign Here**	**Date**
_____	_____	_____
Print Name Here	**Sign Here**	**Date**

Premier Counseling Services Staff

_____	_____	_____
Witness Print Name Here	**Witness Sign Here**	**Date**

Premier Counseling Services

Acknowledgement of RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Premier Counseling Services (PCS) Notice of Privacy Practices ("Notice")

- It tells me how PCS will use my health information for the purposes of my treatment, payment for my treatment, and PCS's health care operations.
- The Notice explains in more detail how PCS may use and share my health information for other than treatment, payment, and health care operations.
- PCS will also use and share my health information as required/permitted by law.
- If I am a PCS patient receiving health services, I consent to PCS using and disclosing my treatment records maintained by PCS for the purposes detailed in PCS's Notice of Privacy Practices.

Name of Patient: _____ **Date of Birth:** _____
(Please print)

Signature: _____ **Date:** _____
(Patient or legal representative*)

*May be requested to show proof of representative status

E-Mail Consent Form

I, _____, grant consent for my mental health care provider, *Premier Counseling Services*, to correspond with me via e-mail for the purpose of scheduling appointments, or conveying general information about my treatment or the treatment of my child. **I understand that e-mail is not a secure form of communication and that confidentiality of any e-mailed information cannot be ensured**.

☐ By checking the box to the left, I am indicating a preference that the text of any e-mail be delivered as an attached, **password-protected** Word Document, using the following password (choose a combination of ***at least nine letters and numbers***): _____". I understand that only the text within the Word document will remain confidential. The confidentiality of the e-mail message itself cannot be assured.

☐ By checking the box to the left, I am granting consent for my mental health care provider to communicate with me via e-mail that is ***not*** password protected. I understand that because e-mail is not a secure form of communication, confidentiality cannot be ensured of any information sent via e-mail.

Please be advised that e-mail is not to be used in order to communicate urgent matters or emergencies. This is not a consent to release information to any specific person other than the client (or the client's parent/guardian when the client is under age 18).

Please indicate your e-mail address: _____

_____ _____

Signature of Client (or parent/guardian of Client under age 18) Date

_____ _____

Premier Counseling Services Witness Date

PATIENT NAME: _____

Medical Records Retrieval Rates

Pursuant to O.C.G.A §31-33-3, effective July 1, of each year, the costs related to medical record retrieval, certification and copy may be adjusted in accordance with the medical component of the consumer price index. Beginning July 1, 2015, the Department of Community Health (DCH) will be the state entity responsible for calculating the annual inflation adjustment and publishing the revised rates for medical records retrieval. Accordingly, the rates effective July 1, 2017 are as follows:

		Previous	Effective July 1, 2017
Search, Retrieval and Other Direct Administrative Costs	Up to:	$25.88	$25.88
Certification Fee	Up to Per Record:	$9.70	$9.70
Copying Costs for Records in Paper Form	Per page for pages 1-20:	$0.97	$0.97
	Per page for pages 21-100:	$0.83	$0.83
	Per page for pages over 100:	$0.66	$0.66

Note: Rates do not apply to records requests necessary to make or complete an application for a disability benefits program or vocation rehabilitation program.

Also, please note that the State Board of Workers' Compensation has instituted medical record retrieval rates that apply specifically to workers' compensation cases. For information on these rates, please contact the State Board of Workers' Compensation at 404-656-2048 or visit the website at http://sbwc.georgia.gov. For inquiries and rates pertaining to medical records retrieval for disability claims, please contact the Georgia Vocational Rehabilitation Agency at 678-639-2100.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____

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Intake/Screening Assessment

Client ID Number: _____

Client's Name: _____ DOB: _____ SSN: ____-____-____

Gender: □ F □ M Age: _____ Grade in school (if applicable): _____ School: _____

Form completed by: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (home): _____ Cell: _____

Work: _____ Email: _____

Emergency Contact & Phone Number: _____

Sexual Orientation: _____ Religious Affiliation: _____

Next Court Date (if applicable): _____

Ethnicity: □ Caucasian □ African-American □ Asian □ Hispanic □ Native American □ Other

Referred By: _____ Date of Referral: _____

Willingness to Participate: □ Enthusiastic □ Cooperative □ Minimal □ Unwilling □ Resistant

1. PRIMARY REASON(S) FOR SEEKING SERVICES (please mark all that apply)

□ Anger Management □ Anxiety □ Depression □ Eating Disorder □ Fear/Phobias
□ Sexual Concerns □ ADHD □ Alcohol/Drugs □ Sexual Abuse □ Oppositional
□ Addictive Behaviors □ Truancy □ Running Away □ Hallucination □ Self-Esteem
□ Paranoia/Delusional □ PTSD □ Physical Abuse □ Emotional Abuse □ Suicidal Ideations
□ Homicidal Ideations □ Self-Mutilation/Cutting □ Marital/Relationship Problems
□ Other Mental Health Concerns (specify): _____

2. FAMILY HISTORY

Parents (if client is 21 years or younger):

With whom does the child live at this time? _____

Parents are: □ Divorced □ Separated □ Never Married □ Living Together

Foster Placement: □ Yes □ No Number of Foster-care Placements: _____

If yes, **who has legal custody?** □ Mother □ Father □ Relative □ Guardian □ State

Client's Mother (if client is 21 years or younger):

Name: _____ Age: _____ Employed: □ Yes □ No □ FT □ PT

□ Natural parent □ Step-parent □ Adoptive parent □ Foster home □ Other: _____

Where employed: _____ Work phone: _____

Client's Father (if client is 21 years or younger):

Name: _____ Age: _____ Employed: □ Yes □ No □ FT □ PT

□ Natural parent □ Step-parent □ Adoptive parent □ Foster home □ Other: _____

Where employed: _____ Work phone: _____

Client Employed: □ Yes □ No □ Full-Time □ Part-Time

Where employed: _____ Work phone: _____

History of Trauma: □ **Yes** □ **No** **If yes, mark one of the following:**

□ Seeing somebody shot or stabbed □ Death of family member □ Adoption □ Divorce
□ Victim of rape □ Witness of rape □ Family violence □ Natural disaster
□ Living with alcoholic or drug addict □ Other: _____

If Applicable, Describe Traumatic Event:

_____
_____
_____
_____

History of Abuse: □ **Yes** □ **No** If yes, by whom was client abused: _____

Type of abuse: □ Physical □ Sexual □ Emotional □ Psychological
Client is: □ Perpetrator □ Witness □ Victim

Family Size: (how many people live in your household?): _____
Client's Relationship with parents: □ Poor □ Average □ Good
Client's Relationship with siblings: □ Poor □ Average □ Good

Has the family been experiencing any financial difficulties in course of the last 6 months? □ Yes □ No
If yes, explain: _____

4. COMMUNITY RESOURCES

Which community resources is your family currently utilizing?
□ Church □ Civic Groups □ Social Services Agency □ Community Action Authority
□ Other: _____

5. FAMILY HEALTH HISTORY

Primary Care Physician: _____ **Telephone:** _____
Have any of the following diseases occurred among blood relatives and the client? (client, parents, siblings, aunts, uncles, or grandparents) Check ALL that apply.

Condition/Disease	Client	Family	Condition/Disease	Client	Family
Allergies			Blindness		
Asthma			Bleeding Tendency		
Deafness			Spinal Bifida		
Glandular Problems			Anemia		
High Blood Pressure			Heart Disease		
Migraines			Mental Health Issues		
Muscular			Diabetes		
Perceptual Motor Disorder			Nervousness		
Cerebral Palsy			Mental Retardation		
Dystrophy			Suicide		
Cleft Lips			Sickle Cell		
Kidney Disease			Cleft Palate		
Cancer			Multiple Sclerosis		
HIV/AIDS			Other:		
Other:			Other:		
Other:			Other:		

List any other comments regarding the client's health:

_____

_____

_____

Does the client have any of the following disabilities?

□ Developmental □ Communication disability □ Cerebral Palsy □ Learning disability
□ Stuttering □ Physical disability □ Deafness □ Blindness
□ Other _____

6. MEDICATION

Is the client currently on any prescribed medications: □ Yes □ No

If yes: Name of Medications Dosage

_____

_____

_____

Is client allergic to any medications? □ Yes □ No If Yes, to What: _____

Is client allergic to anything else? □ Yes □ No If Yes, to What: _____

7. CHEMICAL USE HISTORY

Does the client use or have a problem with alcohol or drugs? □ Yes □ No

If Yes, □ Methamphetamine □ Marijuana □ Alcohol □ Crack Cocaine
□ Prescription Drugs □ Cocaine

Length of use: _____ Frequency of use: _____

History of use:

_____

_____

Does anyone in the household use illegal drugs: □ Yes □ No Who: _____

8. COUNSELING/PRIOR TREATMENT HISTORY

Outpatient Counseling □ Yes □ No Year: _____
Where: _____

Outpatient Counseling □ Yes □ No Year: _____
Where: _____

Inpatient Psychiatric Treatment □ Yes □ No Year: _____
Where: _____

Suicidal Thoughts/Attempts □ Yes □ No Year: _____
Comments: _____

Drug/Alcohol Treatment □ Yes □ No Year: _____
Where: _____

9. BEHAVIORAL/EMOTIONAL STATUS (Please check any of the following that are typical):

□ Aggressive	□ Frustrated Easily	□ Learning Problems	□ Selfish	□ Alcohol issues
□ Gambling	□ Short attention span	□ Hallucinations	□ Anxiety	□ Head banging
□ Sets fires	□ Separation Anxiety	□ Hurts animals	□ Addiction	□ Avoids adults
□ Loner	□ Imaginary Friends	□ Sexual acting out	□ Bedwetting	□ Impulsive
□ Angry	□ Lies frequently	□ Sleeping Problems	□ Lazy	□ Low self-esteem
□ Irritable	□ Careless, reckless	□ Bullies, threatens	□ Sad	□ Lies frequently
□ Steals	□ Suicidal Attempts	□ Suicidal threats	□ Moody	□ Messy
□ Clumsy	□ Cyber Addiction	□ Tics or twitching	□ Nightmares	□ Fearful
□ Talks back	□ Defiant-Oppositional	□ Drugs dependence	□ Destructive	□ Panic attacks
□ Phobias	□ Quarrels	□ Sexual issues		

Does client engage in situations where high risk is involved? □ Yes □ No

If yes: □ Unprotected sex □ Drinking and driving □ Physical fights □ Shoplifting □ Curfew violations

Other_____

Who is the disciplinarian (if client is 21 years or younger)? □ Mother □ Father □ Guardian

How is discipline delivered? _____

What does the client do with unstructured time?

_____

Have there been any significant changed or events in your client's life? □ Yes □ No

If yes _____

_____

10. EDUCATION (if client is 21 years or younger):

Current school (if applicable): _____ School phone number: _____

Type of school: □ Public □ Alternative □ Home schooled □ Private □ College

In special education? □ Yes □ No If yes, is there an IEP, 504 Plan, or SST? _____

Has the child ever been held back in school? □ Yes □ No If Yes, what grade: _____

Have there been any recent changes in the child's grades? □ Yes □ No

If yes, describe: _____

Has the child been tested psychologically? □ Yes □ No If yes, what year(s): _____

11. ADDITIONAL QUESTIONS – (ALL CLIENTS)

1. Is the client going to school?	□ Yes	□ No	
2. 1. Is the client employed?	□ Yes	□ No	
3. Is the client medication compliant?	□ Yes	□ No	□ N/A
4. Is the client chemically dependent?	□ Yes	□ No Evidence	
5. Has the client ever been arrested?	□ Yes	□ No	
6. Is the client presently on probation?	□ Yes	□ No	
7. Is the client a risk to themselves?	□ Yes	□ No Evidence	
8. Is there a history of Trauma?	□ Yes	□ No	

12: How did you hear about Premier Counseling Services? □ My Website □ Internet Search □ Family or Friend □ Facebook □ Doctor □ School Personnel □ Flyer/Brochure □ Co-Worker □ Your Insurance

□ Other: (list) _____

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24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, **PREMIER COUNSELING SERVICES** reserves the right to charge a fee of **$45.00** for all missed appointments ("no shows") and appointments that are cancelled late reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination of service.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

Premier Counseling Services

Insurance Information

All information is held strictly confidential

PATIENT INFORMATION

Name: _____ Today's Date: _____

Address: _____ City: _____ Zip: _____

Phone(Home): _____ (Work): _____ (Other): _____

Social Security #: _____ Date of Birth: _____ ☐ M ☐F

Employer: _____ Primary Physician: _____

Marital Status: _____ Spouse Name: _____

Do you have insurance coverage?: Y or N Referredby: _____

INSURED/RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Employer: _____

Social Security #: _____ Date of Birth: _____

INSURANCE COMPANY INFORMATION

Primary Insurance Co: _____ Phone: _____

Authorization#: _____ Number of Units: _____

Group #: _____ Subscriber #: _____ ID #: _____

Have you met deductible (Circle One): YES NO NOT APPLICABLE

Secondary Insurance Co: _____ Phone: _____

Group #: _____ Subscriber #: _____ ID #: _____

IN CASE OF EMERGENCY PLEASE CALL:

Name: _____ Phone: _____

Assignment of Benefits/Release of Information

I hereby authorize payment directly to the above named provider of any medical benefits payable to me under the condition of my policy for services rendered. I hereby give consent for release to authorize person of financial and medical information concerning care, treatment, and charges as may be required to complete all claims for benefit.

I understand it is my responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by insurance the day and

I understand that I am responsible for all charges, regardless of insurance coverage. Initials_____

Initials_____

Signature of Patient/Guardian: _____ **Date:** _____

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Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**