THE PARENT PILOT
PARENTING ON PURPOSE

Counseling Services - Couples Information Form

Last Name: _____First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Date of Birth: _____

Gender: ☐ Male ☐ Female ☐ Transgender/Gender Non-Conforming

Marital Status: ☐Single ☐Married ☐Divorced ☐Cohabitating Spouse/Partner Name: _____

Emergency Contact/Next of Kin: _____ Phone: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Referred By: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID No.: _____
Subscriber's Name: _____Group No: _____
Subscriber's Date of Birth: _____ Subscriber's Employer: _____

Secondary Insurance: _____ ID No.: _____
Subscriber's Name: _____Group No: _____
Subscriber's Date of Birth: _____ Subscriber's Employer: _____

ACKNOWLEDGEMENT OF RECEIPT OF TERMS OF SERVICE AND CLIENT STATEMENT OF UNDERSTANDING: I have read and understand the Client Statement of Understanding and Terms of Service. I agree to the terms of payment and understand the scope of services provided by Capital Counseling and the program I am utilizing.

INITIALS: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I understand that The Parent Pilot - Counseling services, Notice of Privacy Practices describes the types and uses of disclosure of my protected health information that may occur in my treatment, payment of my bills or in the performance of the behavioral health operations Capital Counseling. By placing my initials in this section, I acknowledge that a copy of The Parent Pilot - Counseling services Notice of Privacy Practices brochure has been provided to me.

INITIALS: _____

Client Signature: _____ Date: _____

© 2020 The Parent Pilot - Counseling Services

The Parent Pilot

Today's Day : _____

Couples Counseling Initial Intake Form

Name: _____ **DOB**:_____

Name of Partner: _____ **DOB**:_____

Relationship Status: (Check all that apply)

- o Married
- o Separated
- o Divorced
- o Dating
- o Living together
- o Living Apart

How long have you and your spouse/partner been together: _____

If married, how many years: _____

How long did you date prior to your marriage? _____

What are your strengths as a couple?

_____

_____

Rank the order of the top three concerns you have in your relationship with your partner (1 being most problematic), and state length of time it has been occurring.

1. _____
2. _____
3. _____

What have you already done to deal with the difficulties?

_____

_____

What do you hope to accomplish through counseling?

_____

_____

Current level of relationship happiness from 1-10, 1=Extremely Unhappy, 10=Extremely Happy _____

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does?

_____

_____

Do either you or your partner drink alcohol or take drugs to intoxication? ❑ Yes ❑ No

If yes: who, how often, and what drugs or alcohol?

_____

_____

Do you ever wish your partner would cut back on his/her drinking or drug use? ❑ Yes ❑ No ❑ N/A

The Parent Pilot

Primary Patient Name: _____

Have you ever received prior couples counseling? ❑ Yes ❑ No

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

Problem(s) treated: _____

_____

What was the outcome? (Check one)

- o Very Successful
- o Somewhat Successful
- o Stayed the Same
- o Somewhat worse
- o Much Worse

Have you ever been involved or been witness to domestic violence? ❑ Yes ❑ No

Please explain below.

_____

_____

Have either of you threatened to separate or divorce (if married) as a result of the current relationship problems? ❑ Yes ❑ No **If yes, who?** ❑ Me ❑ Partner ❑ Both

If married, have either of you or your partner consulted with a lawyer about divorce?

❑ Yes ❑ No **If yes, who?** ❑ Me ❑ Partner ❑ Both

Do you perceive that either you or your partner has withdrawn from the relationship?

❑ Yes ❑ No **If yes, who?** ❑ Me ❑ Partner ❑ Both

How enjoyable is your sexual relationship? 1=Extremely Unpleasant, 10=Extremely Pleasant _____

Satisfaction with frequency of sexual relations? 1=Extremely Unsatisfied, 10=Extremely Satisfied _____

What is your current level of stress in the relationship? 1=No stress, 10=High Stress _____

What is your current level of stress overall? 1=No stress, 10=High Stress _____

How is your relationship issue currently impacting your individual functioning?

_____

_____

Is there any additional information that you feel is important to provide at this time?

_____

_____

_____

_____

_____

_____

_____

_____

The Parent Pilot

Today's Day : _____

Couples Counseling Initial Intake Form

Name: _____ **DOB**:_____

Name of Partner: _____ **DOB**:_____

Relationship Status: (Check all that apply)

- o Married
- o Separated
- o Divorced
- o Dating
- o Living together
- o Living Apart

How long have you and your spouse/partner been together: _____

If married, how many years: _____

How long did you date prior to your marriage? _____

What are your strengths as a couple?

_____

_____

Rank the order of the top three concerns you have in your relationship with your partner (1 being most problematic), and state length of time it has been occurring.

1. _____
2. _____
3. _____

What have you already done to deal with the difficulties?

_____

_____

What do you hope to accomplish through counseling?

_____

_____

Current level of relationship happiness from 1-10, 1=Extremely Unhappy, 10=Extremely Happy _____

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does?

_____

_____

Do either you or your partner drink alcohol or take drugs to intoxication? ❑ Yes ❑ No

If yes: who, how often, and what drugs or alcohol?

_____

_____

Do you ever wish your partner would cut back on his/her drinking or drug use? ❑ Yes ❑ No ❑ N/A

The Parent Pilot

Primary Patient Name: _____

Have you ever received prior couples counseling? ❑ Yes ❑ No

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

Problem(s) treated: _____

_____

What was the outcome? (Check one)

- o Very Successful
- o Somewhat Successful
- o Stayed the Same
- o Somewhat worse
- o Much Worse

Have you ever been involved or been witness to domestic violence? ❑ Yes ❑ No

Please explain below.

_____

_____

Have either of you threatened to separate or divorce (if married) as a result of the current relationship problems? ❑ Yes ❑ No **If yes, who?** ❑ Me ❑ Partner ❑ Both

If married, have either of you or your partner consulted with a lawyer about divorce?

❑ Yes ❑ No **If yes, who?** ❑ Me ❑ Partner ❑ Both

Do you perceive that either you or your partner has withdrawn from the relationship?

❑ Yes ❑ No **If yes, who?** ❑ Me ❑ Partner ❑ Both

How enjoyable is your sexual relationship? 1=Extremely Unpleasant, 10=Extremely Pleasant _____

Satisfaction with frequency of sexual relations? 1=Extremely Unsatisfied, 10=Extremely Satisfied _____

What is your current level of stress in the relationship? 1=No stress, 10=High Stress _____

What is your current level of stress overall? 1=No stress, 10=High Stress _____

How is your relationship issue currently impacting your individual functioning?

_____

_____

Is there any additional information that you feel is important to provide at this time?

_____

_____

_____

_____

_____

_____

_____

_____

Client Statement of Understanding and Terms of Service

Hours of Operations and Scheduling Appointments
Hours of operation are Monday - Thursday 10 am to 8 pm, and Friday 12 pm – 5 pm, weekends by appointment. You may cancel or schedule appointments by calling 678-310-9225 or via email dre@TheParentPilot.com. Cancellations may also be left on voicemail if calling after hours.

Late Cancel
If you cancel your appointment less than 24 hours prior to your appointment time, you will be responsible for paying a $50 late cancel fee.

Contacting your Counselor outside of Normal Business Hours
You may contact your counselor outside of your scheduled session by calling the main office at 678-310-9225. We strive to return calls within 24-48 business hours whenever possible.

Mental Health Crisis Services
We are available to you in cases of emergencies that are not life threatening by dialing 678-310-9225 during business hours. In the case of a life-threatening emergency, after hours, dial 9-1-1.

Your Rights

- You have a right to participate in developing an individual plan of treatment.
- You have a right to receive an explanation of services in accordance with the treatment plan.
- You have a right to participate voluntarily in and to consent to treatment.
- You have a right to object to, or terminate, treatment.
- You have a right to have access to your own records.
- You have a right to receive clinically appropriate care and treatment that is suited to their needs and skillfully, safely, and humanely administered with full respect for their dignity and personal integrity.
- You have a right to be treated in a manner which is ethical and free from abuse, discrimination, mistreatment, and/or exploitation.
- You have a right to be treated by staff who are sensitive to one's cultural background.
- You have a right to be afforded privacy.
- You have a right to be free to report grievances regarding services of staff to the state of Georgia.
- You have a right to be informed of expected results of all therapies prescribed.
- You have a right to request a change in therapist.
- You have a right to have records protected by confidentiality and not be revealed to anyone without my written authorization.

Email Communications
It is not our policy to communicate with clients via email. If you do choose to communicate with your counselor or any staff member regarding your personal health information via email, we cannot ensure the confidentiality of these communications. We also cannot ensure that electronic communications will be returned in a timely manner. Email should not be used for emergency or treatment purposes. If you chose to send email to your counselor, any correspondences will become part of your medical record.

Other Electronic and Social Media Communications
The Parent Pilot – Counseling Services (and related services) may maintain Facebook and other Social Media pages. These pages are intended for information and marketing purposes only and are not to be used to make appointments, or request services of any kind. Your counselor may also have Facebook, Twitter, or other LinkedIn accounts. It is our policy that counselors will not "friend" current or past clients on any social media platform.

The Parent Pilot – Counseling Services does not discriminate (on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability including conditions arising out of acts of domestic violence, disability, genetic information, or source of payment) in the delivery of mental health services.

Additional Information for specific programs:

Counseling
Services are provided based on individual client fees or insurance. You will be advised of the cost of service at the time of your initial appointment. If your service is fee-based or comes with a co-pay, this must be paid prior to your appointment. You must also inform us if there is a change in your insurance coverage. If your insurance lapses without notifying The Parent Pilot – Counseling Services, you will be billed for the allowable rate on any uncovered services. If payment is not provided at the start of a session, the counselor may still provide service, but payment will be due at the start of the subsequent session for both past and present services. If payment is not made at end of the second session, a payment agreement must be made with the Medical Billing Specialist, before further service is provided. A fee of $30 will be charged for any check returned for insufficient funds. Counseling services may be terminated due to lack of payment.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *LPCGA Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Georgia Secretary of State for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a Licensed Professional Counselor in this state and as a member of the Licensed Professional Counselor of Georgia Association it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *LPCGA Code of Ethics* and HIPAA.

Child Abuse or Neglect We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order, or similar process.

Deceased Patients We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies We may use or disclose your PHI in a medical emergency to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety We may disclose your PHI if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research PHI may only be disclosed after a special approval process or with your authorization.

Verbal Permission We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PRIVATE HEALTH INFORMATION (PHI)

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, or for more information and questions about this notice, please submit your request in writing to:

info@TheParenPilot.com

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe your privacy rights have been violated, you have the right to file a complaint in writing at info@theparentpilot.com or with the Georgia Secretary of State at 214 State Capital, Atlanta, GA 30334 or by calling (404) 656-2881. **Under Federal Law, no organization may retaliate against an individual for filing a complaint.**

The effective date of this Notice is November 2020.