New Day Therapy Atlanta LLC
At Cornerstone Family Services
1755 Woodstock Rd. Suite 200
Roswell, GA 30075
770-910-2753 ext. 706

Client Information Form

Date: ________________

Personal Information

Name: ____

Address: ______________________________ City: ___________ Zip: ________

Please circle the best way to contact you in case of emergency.

Phone (Hm): ___________________________ Phone (Wk): __________________

Phone (Cell): ___________________________ Email: _______________________

Date of birth: ___________________________

Referred by: ____________________________ Church: _____________________

If you are a couple, please include partners name and information:

Name: ____

Phone (Wk): ___________________________ Phone (Cell): _________________

Email: _______________________________ Please circle best way to contact.

Date of birth: ___________ How long have you been married: ______________

If you have children, please include the children's names and ages:

Name: ____ Age: ____________

Name: ____ Age: ____________

Name: ____ Age: ____________

Name: ____ Age: ____________

Medical Information

Please indicate the person the information is for: ________________________________

Medical Conditions? ____

Current Medication? ____

Mental Health History

Please indicate the person the information is for: ________________________________

Have your ever seen a counselor/therapist before? ____________ When? ___________

What was the reason? ____

Have you ever been hospitalized for mental health issues? _________________________

Symptoms Currently Experiencing:

__ Sleep Disturbance
__ Poor Concentration
__ Delusions
__ Anorexia
__ Appetite Disturbance
__ Depressed Mood
__ Paranoia
__ Unusual Crying
__ Irritability
__ Low Energy
__ Anxiety
__ Hallucinations
__ Panic Attacks
__ Phobias
__ Sexual Dysfunction
__ Aggressive Behavior
__ Obsessions/Compulsions
__ Bingeing/Purging
__ Abusing
__ Alcohol
__ Diuretics
__ Street Drugs
__ Laxative
__ Prescription Meds

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Rev. **Kenneth Cross, M. Div, LMFT**

Informed Consent for Treatment

Therapy services remain confidential according to the State of Georgia's Marriage and Family Therapist licensing board.
However, Georgia law requires exception to confidentiality in the following circumstances:

a. A client expresses an intent to inflict life-threatening harm to him/herself or someone else
b. Current situations in which a minor or elderly person is experiencing physical and/or sexual abuse; a report must be made to the proper authorities

As a Pastoral Counselor, I cannot prescribe medication, nor can I hospitalize anyone. If those needs are determined, a referral will be made. I do not do forensic testimony or court evaluations.

Therapy is voluntary and you have the right to stop at any time.

Therapy is a fee-for-service relationship and payment is expected at time of service. Fee is based on a sliding scale and will be determined at the first session. I do not take insurance as payment. The normal fee will be charged for appointments cancelled with less than 24-hour notice. All appointments can be made, changed or cancelled by leaving a message on voice mail if I am not in the office.

I have read, understood and consent to these conditions.

Signed ____ Date ____________

Signed ____ Date ____________

Signed ____ Date ____________
(Parent signature if client is a minor)

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Tele-metal Health Informed Consent and Disclosure Agreement

Secure and private communication as well as one's confidentiality, cannot be guaranteed when utilizing cellphones, smart phones, or regular email systems. 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 technology to contact the clinician named in the consent form, shall be considered an implied consent to return messages to the client via the same non-secure technology, pending further clarification for the client. Please check in the spaces below, which modes of communication are permitted and which are not permitted. This consent may be altered at any time if and when the client's circumstances and/or preferences change.

In the event that the client chooses not to allow non-secure communication contact will be made via wire to wire telephone or by mail.

Voice communication to client's cell/smart phone for:

Scheduling Appointments: ___Permitted ___Not Permitted
Contact Between Sessions: ___Permitted ___Not Permitted

Voice communication from clinician's cell/smart phone for:

Scheduling Appointments: ___Permitted ___Not Permitted
Contact Between Sessions: ___Permitted ___Not Permitted

Text communication to client's cell/smart phone for:

Scheduling Appointments: ___Permitted ___Not Permitted
Contact Between Sessions: ___Permitted ___Not Permitted

Text communication from clinician's cell/smart phone for:

Scheduling Appointments:	___Permitted	___Not Permitted
Contact Between Sessions:	___Permitted	___Not Permitted

Contact via the client's email for:

Scheduling Appointments:	___Permitted	___Not Permitted
Contact Between Sessions:	___Permitted	___Not Permitted

If permitted, list the permitted email address: ___________________________________

Teleconferencing based communication to client's portal for:

Scheduling Appointments:	___Permitted	___Not Permitted
Contact Between Sessions:	___Permitted	___Not Permitted

If permitted, list the permitted portal site: _______________________________________

Statement of Authorization:

I have read this Tele-mental Health Consent and Authorization Agreement. It has been adequately explained to me and I understand its contents.

___________________________	_______________________________
Print Clients Name Here	Client Signature Here
___________________________	_______________________________
Print Clients Name Here	Client Signature Here
___________________________	________________________________
Date	Date

Credit Card Authorization Form

I, ________________________, authorize Atlanta/Marietta District Christian Counseling Service, Inc. to charge the following credit card for the amount of ____________, the appointment fee, after appointments have been completed or in the case of cancelation or no show without 24 hours notice of cancelation.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

Credit Card Details

Enter your credit card details exactly as shown on your credit card and billing statement.

Name: ____

Billing Address: ____

Credit Card Type (Visa/MC.AMEX/Discover): __________________________________

Credit Card Number: ____

Credit Card Expiration Date: ____

CVV Code: ____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Signed ____ Date _____________