Talkish Therapy Inc
Ishita Patel, MFT, LMFT
1755 Woodstock Rd. Suite 200
Roswell, GA 30075
770-910-2753, ext. 704
www.cornerstonefamilyservices.com

Child & Adolescent Counseling Intake

Today's Date _____

Child's Name _____ Date of Birth; Age_____

Race/Ethnicity: _____ Religion: _____ Gender: _____

Parent/Guardian's Name (if applicable) _____ Relationship _____

Home Address _____ City _____ Zip Code _____

May I send information to this address? ❑Yes ❑ No

If No, please provide an address where information can be mailed: _____

_____

Home Phone Number _____ May I contact you at this number?

❑ Yes ❑ No ❑ Disguised

Cell Phone Number _____ May I contact you at this number?

❑ Yes ❑ No ❑ Disguised

Work Phone Number _____ May I contact you at this number?

❑ Yes ❑ No ❑ Disguised

Email Address _____ May I email you?

❑ Yes ❑ No

Person to notify in case of emergency _____ Phone _____

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: _____

Referred by _____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

How many sessions do you anticipate to address these concerns?

1-5 6-10 11-20 20+ I don't know

FAMILY INFORMATION

Child lives with: _____

If parents are divorced, describe custody arrangements: _____

Information about child's mother:

Education Level Completed _____ Occupation _____

Are you currently in a relationship? ❑ Yes ❑ No If yes: ❑ Married ❑ Partnered

How long in current relationship? _____ Any previous significant relationships? ❑ Yes ❑ No

Information about child's father:

Education Level Completed _____ Occupation _____

Are you currently in a relationship? ❑ Yes ❑ No If yes: ❑ Married ❑ Partnered

How long in current relationship? _____ Any previous significant relationships? ❑ Yes ❑ No

Please list all the people that live in your household and child's relationship to them:

Name _____ Relationship _____ Age ____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age ____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age ____

Occupation _____ Education Completed _____

Please list any family members who do not live in your house, but are important to your child:

Name _____Relationship _____ Age ____ Where they live _____

Occupation _____ Education Completed _____

Name _____Relationship _____ Age ____ Where they live _____

Occupation _____ Education Completed _____

Has anyone in your family, including parents, siblings, grandparents, aunts and uncles ever suffered from the following:

❑ Depression Who? _____

❑ Anxiety Who? _____

❑ ADHD Who? _____

❑ Bipolar Disorder Who? _____

❑ Schizophrenia Who? _____

❑ Other Who/What? _____

MEDICAL HISTORY OF CHILD

Please explain any significant medical problems, symptoms, or illnesses (e.g., birth complications, diseases, injuries): _____

_____

_____

Current Medications Indication Dosage Frequency Side Effects

Please include over-the –counter medications and vitamins

_____

_____

_____

Past Medications Date(s) Indication Dosage Side Effects

_____

_____

_____

Primary Care Physician: _____ Phone: _____

Last Physical: _____ Concerns: _____

Do you smoke or use tobacco? ❑ Yes ❑ No If yes, how much per day? _____

Do you consume caffeine? ❑ Yes ❑ No If yes, how much per day? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much per day/week/month? _____

Do you use any illicit drugs? ❑ Yes ❑ No If yes, which? _____

Do you exercise? ❑ Yes ❑ No If yes, how often? _____

PSYCHIATRIC/THERAPEUTIC HISTORY OF CHILD

Have you ever talked with a mental health professional before today? ❑ Yes ❑ No

If yes: Date(s) Type of Treatment Reason Professional Seen

_____

_____

_____

Would you like me to contact any of your previous providers? ❑ Yes ❑ No

If yes, please provide their contact information _____

_____

LEGAL ISSUES

Have the concerns you have today resulted in any legal issues? ❑ Yes ❑ No

If yes, please describe briefly: _____

_____

Are you currently involved in any lawsuits, custody battles, or other legal battles? ❑ Yes ❑ No

Is therapy part of any court-mandated requirement that you are required to complete? ❑ Yes ❑ No

SCHOOL INFORMATION

School Name: _____ Grade: _____

School Counselor: _____ Phone: _____

Any concerns: _____

CHILD'S INTERESTS

Hobbies/Interests: _____

_____

What are things your child does well? _____

_____

BEHAVIOR CHECKLIST

Please mark if your child has had difficulty with any of the following currently or in the past:

Mental Health Symptoms

Anxiety	☐ current	☐ past	Time of first onset _____
Depression	☐ current	☐ past	Time of first onset _____
Mood Changes	☐ current	☐ past	Time of first onset _____
Anger/Temper	☐ current	☐ past	Time of first onset _____
Panic	☐ current	☐ past	Time of first onset _____
Fears	☐ current	☐ past	Time of first onset _____
Irritability	☐ current	☐ past	Time of first onset _____
Concentration	☐ current	☐ past	Time of first onset _____
Loss of Memory	☐ current	☐ past	Time of first onset _____
Excessive Worry	☐ current	☐ past	Time of first onset _____
Feeling Manic	☐ current	☐ past	Time of first onset _____
Trusting Others	☐ current	☐ past	Time of first onset _____
Drugs	☐ current	☐ past	Time of first onset _____

Alcohol	☐ current	☐ past	Time of first onset _____
Frequent Vomiting	☐ current	☐ past	Time of first onset _____
Eating Problems	☐ current	☐ past	Time of first onset _____
Severe Weight Gain	☐ current	☐ past	Time of first onset _____
Severe Weight Loss	☐ current	☐ past	Time of first onset _____
Sleeping Too Much	☐ current	☐ past	Time of first onset _____
Sleeping Too Little	☐ current	☐ past	Time of first onset _____
Nightmares	☐ current	☐ past	Time of first onset _____
Head Injury	☐ current	☐ past	Time of first onset _____
Speaking w/o Thinking	☐ current	☐ past	Time of first onset _____
Completing Tasks	☐ current	☐ past	Time of first onset _____
Waiting your turn	☐ current	☐ past	Time of first onset _____
Paying Attention	☐ current	☐ past	Time of first onset _____
Easily Distracted	☐ current	☐ past	Time of first onset _____
Hyperactivity	☐ current	☐ past	Time of first onset _____
Making Careless Mistakes	☐ current	☐ past	Time of first onset _____
Fidgeting	☐ current	☐ past	Time of first onset _____

Relationships

With people in general	☐ current	☐ past	Time of first onset _____
Parents	☐ current	☐ past	Time of first onset _____
Other Family	☐ current	☐ past	Time of first onset _____
Current relationship	☐ current	☐ past	Time of first onset _____
Friends	☐ current	☐ past	Time of first onset _____
Peers	☐ current	☐ past	Time of first onset _____
Teacher(s)	☐ current	☐ past	Time of first onset _____
Employer(s)	☐ current	☐ past	Time of first onset _____
Animals	☐ current	☐ past	Time of first onset _____
Sexual Problems	☐ current	☐ past	Time of first onset _____
History of Child Abuse	☐ current	☐ past	Time of first onset _____
History of Sexual Abuse	☐ current	☐ past	Time of first onset _____
Domestic Violence	☐ current	☐ past	Time of first onset _____

Homicidal Thoughts	☐ current	☐ past	Time of first onset _____
Suicidal Thoughts	☐ current	☐ past	Time of first onset _____

Physical Symptoms

Increased Stress	☐ current	☐ past	Time of first onset _____
Fainting	☐ current	☐ past	Time of first onset _____
Dizziness	☐ current	☐ past	Time of first onset _____
Diarrhea	☐ current	☐ past	Time of first onset _____
Headaches	☐ current	☐ past	Time of first onset _____
Shortness of Breath	☐ current	☐ past	Time of first onset _____
Chest Pain	☐ current	☐ past	Time of first onset _____
Lump in Throat	☐ current	☐ past	Time of first onset _____
Sweating	☐ current	☐ past	Time of first onset _____
Heart Palpitations	☐ current	☐ past	Time of first onset _____
Muscle Tension	☐ current	☐ past	Time of first onset _____
Pain in Joints	☐ current	☐ past	Time of first onset _____
Allergies	☐ current	☐ past	Time of first onset _____
Chills	☐ current	☐ past	Time of first onset _____
Hot Flashes	☐ current	☐ past	Time of first onset _____

Others Issues

Adjustments/Changes	☐ current	☐ past	Time of first onset _____
School Performance	☐ current	☐ past	Time of first onset _____
Self-esteem	☐ current	☐ past	Time of first onset _____

Any additional information that you would like to include _____

_____

_____

_____

Therapy Goals

What do you hope your child gains from seeing a therapist? _____

_____

_____

_____

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INFORMED CONSENT

The following contains important information about the professional services provided by Ishita Patel, MFT, LMFT. This document is designed to inform you about what you can expect from me regarding my understanding of therapy, confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is a part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Should we choose to enter into a therapeutic relationship, please know that it is a collaborative experience and I welcome any questions, comments, or suggestions at any time. By you signing this document, we enter into an agreement that allows me, Ishita Patel, MFT, LMFT, to provide therapeutic services to you.

Background Information

I received my Bachelor of Arts in Psychology from Mercer University, College of Liberal Arts, in 2014 and a Master of Family Therapy from Mercer University, School of Medicine, in 2017. I am licensed in the state of Georgia as a Marriage and Family Therapist and am currently pursing my certification as a Registered Play Therapist under the supervision of Trudy Post Sprunk, LMFT, LPC, RPTS, EMDR, CPCS. I have been providing therapeutic services to children, adolescents, adults, families, couples, and groups since 2016. My professional experiences include working in a university mental health clinic, non-profit organization, agency, and private practice settings. I am the owner of Talkish Therapy Inc and am contracted with Cornerstone Family Services, LLC to provide therapy services at 1755 Woodstock Rd., Suite 200, Roswell, GA 30075. Within past and current settings, I have worked with diverse populations experiencing various mental health issues such as depression, anxiety, domestic violence, sexual assault, behavioral issues, etc. Additionally, I am an active member of my professional organization at both the local and state levels.

Theoretical Views, Client Participation, and Client Welfare & Risks

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist/group leader at any point.

In sessions, I practice using a systemically structural approach to navigate through the therapeutic process. My goal is to facilitate healing and growth within a safe environment, and I am very committed to helping you in whatever way seems to produce maximum benefit. In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that you are

capable of facing life's challenges in the future without your therapist. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me know if you feel that transferring to another facility or another therapist is necessary at any time.

Given the work required for personal growth and change to occur, therapy may involve some risks. Since therapy involves discussing difficult aspects of life, you may experience uncomfortable feelings or strong reactions. Making and adapting to changes in your life may have a profound impact on you and your relationships as well as challenge long held assumptions or behaviors. Reasonable efforts will be made to discuss the potential impact, positive and negative, that may result from the changes you make in your life as a result of therapy. Please ask questions if you have any concerns. There are no guarantees for successful therapy due to the overall complexity of the process and the multiple variables brought into it by each individual.

Additionally, at times, people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Services Provided

During your first session, I will speak with you about the reasons that you scheduled your first appointment. If you are seeking therapy for your minor child, I require that I meet with the parent(s)/guardian(s) *alone* for the first session. Finding the right fit for your treatment is an important part of the therapeutic alliance. It may take several sessions for you and I to determine if I am the therapist best suited to work with you. If at any point there is need for a referral to be made to a therapist who better fits your needs, I will provide contact information for at least 3 alternative treatment providers. I encourage you to interview several therapists to find the best fit for you/your family. Each therapy session typically lasts 45-50 minutes. The duration of the therapeutic process varies for each client. Some clients may feel resolution to their concerns in just a few sessions while others may take years to complete their process. Please note that when working with children, the therapeutic process typically takes longer and is slower. Children need to feel comfortable with the therapist with whom they are working and processing significant issues require high levels of trust and safety.

If at any time you wish to stop receiving services from me, I ask that you schedule one final session in order for us to have appropriate closure and to address any remaining needs that you may have.

Fees

Clients seen by Ishita Patel, MFT, LMFT agree to pay $135.00 per 45-50 minute Individual, Couple, or Family session. Services will be provided by Ishita Patel, MFT, LMFT and all payments will be made to Talkish Therapy Inc. Any services beyond the standard 45-50 minute session, such as phone consultation exceeding 20 minutes, excessive paperwork, attending school meetings or court appearances/preparation, will incur additional fees as listed above. Ishita Patel, MFT, LMFT, reserves the right to announce fee increases, which upon effective date shall become current for all existing clients. I will be happy to provide you with a receipt for payment. Receipts of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $25 fee for returned checks. Should you miss a payment, for whatever reason, therapy

sessions may be postponed until the full payment is rendered. You are responsible for the full payment at the time service is provided.

I also provide a *limited* number of reduced-fee spaces in my caseload. If you feel that you qualify for one of these slots, please inform me at the *beginning* of our first session. Because these slots are limited, there may be a waiting list. If there are no slots immediately available, I am able to provide you with other low-cost or sliding-scale referrals.

Insurance companies have many rules and requirements specific to certain plans. If you choose to file with your insurance company for reimbursement, it is your responsibility to understand their policies and requirements for reimbursement. I will be glad to provide you with a statement for your insurance company provided you sign a written release of information giving me permission to do so.

Cancellations

You are expected to attend all scheduled sessions with your therapist. I understand that "life happens" and that unexpected interruptions occur particularly with children and adolescents, but I do expect you to make therapy a priority. If you need to cancel your appointment, please call NO LATER THAN 24 HOURS PRIOR to your scheduled appointment. You will be charged the full session fee of $135.00 depending on the type of scheduled appointment that is cancelled with less than 24 hours notice. Talkish Therapy Inc requires all clients to provide a credit card number to keep on file in the case of missed or cancelled appointments. This information is kept in a confidential file that is locked at all times. If you "no show" or cancel your appointment without 24-hour notification the $135.00 cancellation charge will be charged to your card. Please note that insurance companies do not reimburse for missed appointments.

Any files that have no activity for a period of 3 months will be considered closed.

Working with Children

Due to the importance of trust between client and therapist, when the client is a minor child I will offer parents general information about the therapeutic process and overall themes, but not specific details about what information is exchanged during each session. If, at any time, I feel like your child is engaging in risky/dangerous behavior I will immediately inform you of the situation, or have your child do so as part of the therapeutic process. My definition of "risky/dangerous behavior" includes, but is not limited to: self harm or suicidal ideation, homicidal threats, threats of running away, any use of hard drugs, prolonged use of soft drugs, and unprotected sex. I will regularly update you on your child's progress and I encourage you to contact me as frequently as you feel is needed. I will not provide you updates after each session, however if you need to speak with me about your child's behavior please call prior to their weekly session or arrange a time to come in and speak with me. It is important that your child feel that my office is a place where they can trust me enough to share the sensitive things that may be underlying the presenting problem. I am sensitive to a parent's needs to be involved in the process and that is why parenting and family sessions are typically a regular occurrence during the treatment process. If at any time, your child expresses interest in their parent(s) to join their therapy sessions, I will ask you to sign a Collateral Informed Consent prior to inviting you into sessions.

Confidentiality

The information you share with me both written (i.e. intake paperwork) and verbally is part of your Protected Health Information (PHI) and is considered confidential. A detailed description of PHI is included with this intake packet. I will not release your information to anyone, including your family and insurance company if you

are a legal adult, without *written* consent. If you are a minor, it is the legal right of your parents to have access to the information that we discuss in our sessions. I will discuss with each minor client and their parent/guardian the expectations of exchange of information between parent/child, therapist/child, and therapist/parent for their particular situation. It may be imperative to my therapeutic relationship with a child or adolescent not to reveal the information disclosed to me in session to their parents/guardians. It is important that all parties involved in the therapeutic process are clear on our communication expectations.

All communication between the client and therapist are confidential and will not be disclosed *unless required by law* such as in, but not limited to, the following situations:

1. If I believe that you are a danger to yourself, I will take action to protect your life and assure your health and safety. This means I may reveal your identity to do so.
2. If you threaten serious bodily harm to someone else, I will take action to protect and assure the health and safety of all those concerned. This means I may reveal your identity to do so.
3. As a mandated reporter, if I suspect the abuse and/or neglect of a child, elder, or vulnerable adult, I am required to file a report with the appropriate state authorities.
4. If I suspect another therapist has placed sexual exploitation upon you, I am required to file a report with the appropriate agency.
5. When a judge orders that information be disclosed, I cannot guarantee that an appeal will be upheld, but I will do everything in my power not to disclose your confidential information.
6. When Homeland Security requests information, according to the Patriot Act.

No Secrets Policy Please note that in couple's therapy, I do not agree to keep secrets. Information disclosed in any context may be discussed with either partner.

Waive right to subpoena

In order to protect you and the information you and/or your child(ren) provide to me during our sessions, I ask each client to waive their right to call me as a witness to court for any reason. The communication that you/your child(ren) provide during session is considered privileged by O.C.G.A. §24-9-21(7) and covers communication provided by "a licensed…marriage and family therapist… during the psychotherapeutic relationship." This would include any interaction between therapist and the court system, attorneys, guardian ad litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system during therapy services and/or after therapy termination. If you anticipate the need for a therapist's involvement in court activity, I will be happy to refer you to someone who is more suited to meet your needs. If, for any reason, I am required to participate in court proceedings, I will execute a proper Release of Information, which you will be responsible for charges in producing any records needed for court. I reserve the right to charge for court preparation including case review, report preparation, and legal and ethical review at $270 per hour, which will be applied door to door for any interaction between myself and anyone in the legal system. If you believe it is necessary to subpoena me to testify at a deposition or a hearing, you would be responsible for my witness fees in the amount of $1500.00 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 the one-half (1/2) day would be billed at the rate of $270.00 per hour including travel time. Additionally, I ask that you understand that if you subpoena me, I may elect not to speak with any attorney representing the client and/or client's family, and a subpoena may result in myself withdrawing as the client's therapist.

Clinical Diagnosis for Insurance Purposes

Many clients decide to seek reimbursement for services through their insurance company. While I do not accept any forms of insurance directly, I am willing to provide you a "superbill" with information that will help you seek reimbursement from your insurance company. Please be advised that most insurance companies require a diagnosis in order for reimbursement to occur. Any diagnosis submitted to an insurance company will become a part of you/your child's permanent medical record.

Methods of Communication

The best way to contact me for any reason is by phone at 770-910-2753, ext. 704. I prefer not to use email as a primary form of communication. Should we need to utilize email I have a HIPAA compliant platform in which we can discuss appointment information or share documentation only. At no time should email be used as a way to share details about your treatment or 'updates' unless discussed by you and I BEFOREHAND. Anything you email me is required to be placed into your file. The current voicemail system does not allow for texting at this time. Again, calling is the best method of communication at this time.

Professional Relationship

Your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

Social Media

I am restricted by the Code of Ethics by which I abide from entering into dual relationships with clients except in very limited circumstances where these relationships would be beneficial to you. "Dual relationship" means any relationship outside of our therapeutic relationship. To abide by this code, I am not able to accept any requests to friend, like, or otherwise connect via the web or social media sites such as Instagram, Facebook, LinkedIn, and Twitter.

Protecting Your Privacy

To protect your privacy, if we happen to see each other outside of session I will not initiate contact (e.g. say hello, indicate that we know one another) unless you choose to do so first.

Supervision/Case Consultation

Supervision/case consultation helps to ensure that you and your family are receiving the best of care and that appropriate measures are being taken to ensure that your needs are being met. I have contracted with a State Board approved

supervisor to oversee cases that I feel the need to seek guidance on. This supervisor is legally bound to all the confidentiality restrictions listed above. Your case may or may not be discussed with a supervisor, or in case consultation, at some point during your work with me. During supervision/case consultation, I do not disclose names of clients or specific identifying information. If you have any questions about this process, you are encouraged to ask them at any point during your time in therapy. I am currently under the supervision of Trudy Post Sprunk, LMFT, LPC, RPTS, EMDR, CPCS as I pursue my certification as a Registered Play Therapist.

Upon my permanent incapacitation or death

In case of any personal emergency when I am unable to contact my clients, I have designated Jennifer D. Vann, LMFT, to have access to my client's first name(s) and contact information only. Your contact information is kept in a secure location on the premises of Cornerstone Family Services and only my designee has access to it. Again, this is only your contact information. No other information is available except as noted in the paragraph below.

In case of my death or permanent incapacitation Jennifer D. Vann, LMFT has agreed to abide by my confidentiality statement (listed in this informed consent) and will become the sole owner of all case files held in my possession at that time. Any dissemination of information from those files will then be at the discretion and clinical judgment of Ms. Vann. Upon my permanent incapacitation Ms. Vann may be contacted at 770.910.2753, ext. 701.

Emergencies

Ishita Patel, MFT, LMFT, does not provide emergency services. I do not carry a pager, and I am not available at all times. If this does not feel like it will be sufficient support for you, please inform me and we can discuss additional resources or transfer your case to a therapist or clinic that has 24-hour availability. Generally, I will return phone calls within 24-48 hours. Should I be out of town, I will make every effort to alert you of my absences. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one of more of the following:

1. Call Ridgeview Institute at 770.242.4567 or Peachford Hospital at 770.454.5589
2. Call 911
3. Go to the emergency room of your choice
4. Georgia Crisis and Access Line (GCAL) 1.800.715.4225 (available 24/7)
5. Cobb County Mental Health Crisis Line 770.422.0202
6. Fulton County Mental Health Crisis Line 404.730.1600

Ethical Considerations

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Association for Marriage and Family Therapy. I make it a priority to be familiar with the AAMFT Code of Ethics and to structure my practice to follow those guidelines. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the Georgia Association for Marriage and Family Therapy and the American Association for Marriage and Family Therapy, both which govern my profession.

In order to maintain ethical standards I find it helpful to occasionally consult with other professionals. In these consultations I do not reveal the identity of my client(s). The consultant is also bound to keep any information about a case confidential by the ethical standards of their own professional association. I do not consult with therapists who are not bound by such ethical standards.

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Please keep the above information for your record. Return only this page.

Consent to Treatment

By signing below you agree that you have read (or have had read to you) all of the above sections of the informed consent form and that you understand the risks and benefits associated with the therapeutic process. You understand that you can ask questions about the process at any time. You agree to pay the disclosed fee for services rendered and to provide 24 hours notice to cancel your appointment.

If Applicable:

_____ _____

Signature (Client/Parent/Guardian) Date Minor's Name

_____

Signature Date

_____

Signature Date

_____

Signature Date

Initial here:

_____ I have read & understand the "Working with Children" section.

_____ I have read & agree to the "Waive Right to Subpoena" section.

_____ I have read & agree to the "No Secrets" policy.

_____ I have read & understand the "Cancellation" section.

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CREDIT CARD POLICY

I am hereby entering into a contract for Ishita Patel, MFT, LMFT's professional time and services when I set an appointment. I understand that by entering into this contract for Ms. Patel's professional time I am specifically contracting for her services to prepare for my session in advance. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and consultations with other professionals as agreed in writing by me to assist with my treatment. I understand that Ms. Patel's cancellation policy requires 24 hours advance notice in order to be released from the contract for her time and services of preparation for my session. I agree that if I fail to cancel my appointment before the 24 hour minimum time period prior to my session I will be charged for the missed session and the services provided in preparation of $135.00 for Individual, Couple, or Family sessions. I hereby authorize Talkish Therapy Inc to charge the following card if I indeed fail to observe this cancellation policy and I understand I am paying for preparation services rendered and time contracted for when I set the appointment.

Visa / Mastercard / Discover (please circle)

Credit card number_____

Expiration date_____ CVV code (last 3 digits on the back of the card)_____

Zip code to which billing statement is mailed_____

Name on credit card _____

I have read and understand the above credit card policy for services provided by Ishita Patel, MFT, LMFT through Talkish Therapy Inc. Please have all consenting adults sign below.

_____ _____
Signature Date

_____ _____
Signature Date

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PRIVACY PROTECTION NOTICE

Please keep these pages for your records

This notice shall go into effect April 15, 2011 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

I. Preamble

A recent United State Supreme Court decision held that communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. **PHI consists of three (3) components: *treatment, payment, and health care operations.***

Treatment refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you.

Health care operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The ***use*** of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks *within* my office related to your care.

Disclosures refer to activities you authorize which occur *outside* my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so.
There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-client in

treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate from the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are *my* notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your protected health information to only your "designated record set" which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of you care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your "designated mental health record."
You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative service over my therapeutic work and refers to these people as "Business Associates." I do consult with business associates to assist with my administrative matters and these business associates are indeed trained and monitored so that your privacy is ensured at all times.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out "Duty to Warn" Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

I never release any information of any sort for marketing purposes.

V. Client's Rights and My Duties

You have a right to the following:

- *The right to request restrictions* on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- *The right to receive confidential communications by alternative means and at alternative locations.* For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;

- *The right to inspect and receive a copy* of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- *The right to amend* material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- *The right to an accounting of non-authorized disclosures* of your protected health information;
- *The right to a paper copy* of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- *The right to revoke your authorization* of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s). My duties as a Licensed Marriage and Family Therapist on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executing private practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

VI. Complaints

Ishita Patel, MFT, LMFT is the appointed "Privacy Officer" for my practice per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to contact her immediately about this matter. You will always find her willing to talk to you about preserving the privacy of your protected mental health information. You can reach her by letter at 1755 Woodstock Rd. Suite 200, Roswell, GA 30075 or by phone at 770.910.2753. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client protections related to the electronic transmission of data (the transaction rules), the keeping and use of client records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Ishita Patel, MFT, LMFT

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RECEIPT OF PRIVACY NOTICES

I, _____, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____
Client Signature or Parent if Minor or Legal Charge Date

If Legal Charge, describe representative authority: _____

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual home. I wish to be contacted in the following manner (check all that apply):

Home Phone Number:_____
___OK to leave message with detailed information
___Leave VM with name & call back number only
___Do not leave messages at home number
___Do no call me at this number

Work Phone Number: _____
___OK to leave message with detailed information
___Leave VM with name & call back number only
___Do not leave messages at home number
___Do no call me at this number

Cell Phone Number: _____
___OK to leave message with detailed information
___Leave VM with name & call back number only
___Do not leave messages on cell number
___Do no call me at this number

Written Communication
___OK to mail to my home address
___OK to mail to my work/office address

_____ _____
Client/Parent/Guardian Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: USES AND DISCLOSURES MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.

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Release of Information

This form must be completed in full in order to be valid

Client's name _____ Date of Birth _____

I hereby request and authorize Ishita Patel, MFT, LMFT:

□ To Release To _____ (Must be an individual's name. No Organizations)

Address _____

_____

Phone _____

Fax _____

□ To Request From _____

Address _____

_____

Phone _____

Fax _____

The following information:

□ Psychiatric Evaluation □ Social History

□ Laboratory Reports □ Care Plan

□ Summary of Treatment □ Attendance

□ Clinical Assessment

□ School Information

□ Other (please describe) _____

_____

_____

For the purpose of: □ Coordination of Treatment □ Other _____

Medical records frequently contain information which may be privileged and/or confidential. This could include remarks furnished by the client, client's family, or medical staff. If, in the judgment Ishita Patel, MFT, LMFT disclosure of the privileged/confidential information will be harmful to the client, release of such information may be withheld in accordance with specific state and federal regulations. Records released may contain alcohol and drug treatment information, AIDS/HIV, psychiatrics/psychological/and other mental health privileged/confidential information. Certain communications are privileged and not subject to release without your consent understate and/or federal law. Please note that once information has been released to the designated party Ishita Patel, MFT, LMFT, nor Talkish Therapy Inc are liable for the misuse of information by that party.

After giving due consideration to the above statement, I authorize Ishita Patel, MFT, LMFT, to furnish/receive information, including faxed copies of my Protected Health Information, including matters privileged under the laws of the state of Georgia, and applicable federal laws and regulations, to the above person(s). I further agree to indemnify and hold harmless Ishita Patel, MFT, LMFT, and Talkish Therapy Inc from all liability that may arise from the release of the information herein requested.

□ By checking this box I agree that information may be shared electronically with other professionals via email. I understand that the security of email servers cannot be guaranteed and I accept the risk associated with electronic transfer of information.

I understand that this authorization is subject to revocation at any time *in writing* except to the extent that action has been taken in reliance and is only valid for a period of 1 year from the date of my signature unless I specify another date or event here: _____

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_____ _____

Client/Parent/Legal Guardian Signature Date

_____ _____

Therapist Signature Date

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Directions to Cornerstone Family Services

From I-75: Exit 267A. At first light you will turn right onto Sandy Plains Rd. Drive 8.5 miles until Sandy Plains Rd. Ts into Woodstock Rd/Hwy 92. Turn RIGHT. At the second light MAKE A U-TURN at Willow Springs Neighborhood and take an immediate right into 1755 Woodstock Rd. Suite 200 is located in the building with Modern Dentistry.

From Roswell: Travel 92 west. CFS is located at 1755 Woodstock Rd. Suite 200 just past Willow Springs Neighborhood. We are located in the building with Modern Dentistry.

From Woodstock/Canton: Follow Hwy 92 east toward Roswell. We are two lights past the Movie Tavern. At the second light MAKE A U-TURN at Willow Springs Neighborhood and take an immediate right into 1755 Woodstock Rd. Suite 200 is located in the building with Modern Dentistry.