Talking Solutions

# Anger Management & Counseling Center

2020 Avalon Parkway Suite #185 talkingsolutionsamcc@yahoo.com

McDonough, GA 30253 http://www.talkingsolutionsamcc.com

678.833.1820 **PH**  678.833.1821 **FAX**

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CHILD INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: \_\_\_\_\_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_ \_\_\_\_\_\_\_

FIRST MIDDLE INITIAL LAST DATE OF BIRTH AGE

Gender:  Male  Female

Mother’s Name: \_\_\_\_\_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Natural parent: \_\_\_\_ Relative: \_\_\_\_

Step parent: \_\_\_\_ Adoptive parent: \_\_\_\_

Father’s Name: \_\_\_\_\_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Natural parent: \_\_\_\_ Relative: \_\_\_\_

Step parent: \_\_\_\_ Adoptive parent: \_\_\_\_

Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET CITY ST ZIP

Home Phone: (\_\_\_\_) \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Workplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

NAME OF COMPANY

**Please check off contact number(s) where we may leave a message:**  HOME: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s SSN#: \_\_\_\_\_\_\_\_\_--\_\_\_\_\_\_\_\_--\_\_\_\_\_\_\_

|  |
| --- |
| **ALTHOUGH WE HAVE YOUR CHILD’S INSURANCE CARD, THIS SECTION MUST BE FILLED OUT COMPLETELY IN ORDER TO PROPERLY BILL THE INSURANCE COMPANY.**  INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEMBERID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  EMPLOYEE HOLDING INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_  DATE OF BIRTH  EMPLOYEE SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  RELATION TO CLIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DO YOUR CHILD HAVE MORE THAN ONE INSURANCE CARRIER?  Yes  No  **IF YOUR CHILD IS COVERED UNDER TWO INSURANCES, WE MUST HAVE THE FOLLOWING INFORMATION:**  SECONDARY INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NAME OF POLICY HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MEMBER ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\*\*\*IF WE DO NOT RECEIVE THIS INFORMATION, YOU WILL BE RESPONSIBLE FOR ANY PAYMENT DUE AT THE TIME OF SERVICE. \*\*\*** |

Medical Information: ***I would like information about my child’s counseling disclosed to my child’s doctor.***  Yes  No

Name of Doctor: Name of Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Address: Phone: Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what is your child seeking help with today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Presenting Problems (check all that apply):

\_\_\_ Temper outbursts \_\_\_ Impulsive \_\_\_ Shy \_\_\_ Other (explain):

\_\_\_ Withdrawn \_\_\_ Stubborn \_\_\_ Strange behavior \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Daydreaming \_\_\_ Disobedient \_\_\_ Stealing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Fearful \_\_\_ Infantile \_\_\_ Lying \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Clumsy \_\_\_ Mean to others \_\_\_ School trouble \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Overactive \_\_\_ Destructive \_\_\_ Bowel/bladder control

\_\_\_ Short attention span \_\_\_ Bed wetting \_\_\_ Feeding/eating problems

\_\_\_ Distractible \_\_\_ Self mutilating \_\_\_ Sleeping problems

\_\_\_ Peer conflict \_\_\_ Head banging \_\_\_ Drug/alcohol abuse

\_\_\_ Phobic \_\_\_ Rocking \_\_\_ Sickly

**MEDICAL HISTORY**

Has the child ever been hospitalized for illness, physical ailments, emotional problems, etc.? Y\_\_\_ N \_\_\_ If yes, please explain where, when, and what for?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has the child ever taken, or is he/she currently taking any medications? Y \_\_\_\_ N \_\_\_\_

If yes, please list medication name and frequency of dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does the child have any allergies that you are aware of (i.e. latex, peanut, soy, etc.)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name and address of primary care physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**LIVING ARRANGEMENTS**

Number of moves in child's life\_\_\_\_ Ever placed, boarded, or lived away from family? Y\_\_\_ N \_\_\_  
Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present home: Renting\_\_\_ Buying\_\_\_ House\_\_\_ Apartment\_\_\_

List all members of your household presently and indicate their relation to the patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you interested in counseling services for yourself or any of your family members? Y\_\_\_ N\_\_\_

**DEVELOPMENTAL HISTORY**

Did mother have any illness or complications before delivery? Y\_\_\_ N \_\_\_ If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Did mother abuse alcohol or drugs during pregnancy? Y\_\_\_ N \_\_\_

Length of pregnancy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full Term? Y\_\_\_ N\_\_\_ Birth Weight \_\_\_\_ Ibs \_\_\_\_oz

Complications at birth? (Explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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As far as you know, did your child meet developmental milestones at an appropriate age (i.e. rolling, sitting up, babbling, and eating)? Y \_\_\_\_ N\_\_\_\_

**EDUCATIONAL HISTORY**

Name of School/Daycare\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Types of classes: \_\_\_\_ Regular \_\_\_\_ Inclusion \_\_\_\_ ESE \_\_\_\_ EDB (Emotionally Disturbed Behavior)

\_\_\_\_ Other (explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child receive special services at school? Y \_\_\_ N \_\_\_\_ If yes, which services and what is the frequency/ duration of each?

\_\_\_\_ Occupational Therapy \_\_\_\_ / week for minute sessions

\_\_\_\_ Physical Therapy \_\_\_\_ / week for minute sessions

\_\_\_\_ Speech Therapy \_\_\_\_ / week for minute sessions

\_\_\_\_ Counseling \_\_\_\_ / week for minute sessions

**SOCIAL HISTORY**

Does the child attend extracurricular activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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In school, how many friends does the child have?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name of person completing information/ relationship to child Date

**EYBERG CHILD BEHAVIOR INVENTORY**

Child's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_ Child's Age:\_\_\_\_

Rater's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Rating:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Directions:***

Below is a series of phrases that describe a child's behavior. Please:

1.) circle the number describing how often the behavior occurs with your child

2.) circle either "yes" or "no" to indicate whether the behavior is currently a problem

**(1)-Never (2)-Almost Never (3)-Seldom (4)-Sometimes (5)-Often (6)-Almost Always (7)-Always** Is this a Problem Now? Yes No

1. Dawdles in getting dressed 1 2 3 4 5 6 7 Yes No

2. Dawdles or lingers at mealtime 1 2 3 4 5 6 7 Yes No

3. Has poor table manners 1 2 3 4 5 6 7 Yes No

4. Refuses to eat food presented 1 2 3 4 5 6 7 Yes No

5. Refuses to do chores when asked 1 2 3 4 5 6 7 Yes No

6. Slow in getting ready for bed 1 2 3 4 5 6 7 Yes No

7. Refuses to go to bed on time 1 2 3 4 5 6 7 Yes No

8. Does not obey house rules on his own 1 2 3 4 5 6 7 Yes No

9. Refuses to obey until threatened w/punishment 1 2 3 4 5 6 7 Yes No

10. Acts defiant when told o do something 1 2 3 4 5 6 7 Yes No

11. Argues with parents about rules 1 2 3 4 5 6 7 Yes No

12. Gets angry when doesn’t get own way 1 2 3 4 5 6 7 Yes No

13. Has temper tantrums 1 2 3 4 5 6 7 Yes No

14. Sasses adults 1 2 3 4 5 6 7 Yes No

15. Whines 1 2 3 4 5 6 7 Yes No

16. Cries Easily 1 2 3 4 5 6 7 Yes No

17. Yells or screams 1 2 3 4 5 6 7 Yes No

18. Hits parents 1 2 3 4 5 6 7 Yes No

19. Destroys toys or other objects 1 2 3 4 5 6 7 Yes No

20. Is careless with toys and other objects 1 2 3 4 5 6 7 Yes No

21. Steals 1 2 3 4 5 6 7 Yes No

22. Lies 1 2 3 4 5 6 7 Yes No

23. Teases or provokes other children 1 2 3 4 5 6 7 Yes No

24. Verbally fights with friends his own age 1 2 3 4 5 6 7 Yes No

25. Verbally fights with brothers and sisters 1 2 3 4 5 6 7 Yes No

26. Physically fights with friends 1 2 3 4 5 6 7 Yes No

27. Physically fights with brothers and sisters 1 2 3 4 5 6 7 Yes No

28. Constantly seeks attention 1 2 3 4 5 6 7 Yes No

29. Interrupts 1 2 3 4 5 6 7 Yes No

30. Is easily distracted 1 2 3 4 5 6 7 Yes No

31. Has short attention span 1 2 3 4 5 6 7 Yes No

32. Fails to finish tasks or projects 1 2 3 4 5 6 7 Yes No

33. Has difficulty entertaining himself alone 1 2 3 4 5 6 7 Yes No

34. Has difficulty concentrating on one thing 1 2 3 4 5 6 7 Yes No

35. Is overactive or restless 1 2 3 4 5 6 7 Yes No

36. Wets the bed 1 2 3 4 5 6 7 Yes No

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## Patient Information & Consent for Treatment

*Welcome to our office. We want to help make your experience with us as pleasant as possible. Please feel free to ask questions about anything you do not understand.*

**ALL CLIENTS:**

* Our office initial fee is **$125**; follow up visits are **$95** per session (50 min.). Please note payment is due at the time of service.
* We currently accept cash, credit cards (MasterCard, VISA, Discover) and/or checks as a form of payment.
* In order to maintain standing appointments, your account must be kept current.

**CLIENT WHO ARE MINORS:**

* The adult accompanying a minor or the parent/guardian are responsible for full payment.
* Except in emergency situations, minors who are unaccompanied by an adult will be denied services, unless a payment has been pre- arranged.

**SOCIAL MEDIA SESSIONS:**

* Skype and phone sessions are available to military families during deployment; however, spouse must come into the office.
* Skype sessions for regular clients will have to have to be determined on a case by case basis and cannot be conducted on an initial session.

**FINANCIAL POLICY:**

You are fully responsible for all services rendered. Full payments for sessions, co- payments, co- insurance, deductibles or fees are expected at the time of service, unless other contractual arrangements apply. **Please make checks payable to Talking Solutions AMCC.** We also accept credit card payments (MasterCard, VISA, Discover).

There will be a **$35.00 fee** for **returned checks** as non- sufficient funds or non- payable. You will receive an invoice from our office letting you know the total amount.

**Cancellations must be made at least 24 hours prior to your scheduled appointment. A $75.00 fee (not covered by insurance) will be applied for late cancellations or missed appointments, due prior to next appointment.**

**Court services** are not a part of mental health treatment. If you require our services on any court proceeding, additional fees will apply. Please note that court- related fees are not covered by insurance. Court services are billed at **$125.00** per hour and will include preparation time, travel time and court time (even if never called to witness). A deposit of **$250.00** is required in advance of the court date.

If you require your therapist to complete forms or prepare documents regarding your participation and progress in treatment for a third party (other than insurance), a **$75.00 document fee** will apply.

It is your responsibility to know your **insurance benefits**. Please be aware that mental health benefits vary widely in coverage, and regular co-pay information often does not apply. In the event that your insurance carrier determines a service to be **“non- covered”**, or in not paid within **90 days of service**, you will be responsible for the charges. **Disputes** over coverage must be handled between you and your insurance company. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract and are not authorized to **reduce or waive co- payments** on your behalf.

If you have questions regarding your account, please contact our office manager at (678)833-1820.

**\*\*\*I have read and fully acknowledge the policies of this office including payments and insurance. I agree to comply and accept responsibility for any payment that becomes due as previously outlined. \*\*\***

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Signature of Patient/ClientDate

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Signature of Responsible Party (if different) Relationship Date

Talking Solutions

# Anger Management & Counseling Center

2020 Avalon Parkway Suite #185 http://www.talkingsolutionsamcc.com

McDonough, GA 30253 talkingsolutionsamcc@yahoo.com

678.833.1820 **PH**  678.833.1821 **FAX**

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## NOTICE OF PRIVACY PRACTICES

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian. Noted exceptions are as follows:

**Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**Minor/Guardianship**

Parents or legal guardians of non- emancipated minor clients have the right to access the clients’ records.

**Insurance Providers** (when applicable)

Insurance companies and other third party payers are given information that they request regarding services to clients. Information that may be requested includes, but it is not limited to; types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

*If we receive a subpoena or similar legal process demanding release of any information about you we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.*

**I agree to the above limits of confidentiality and understand their meanings and ramifications.**

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Client Signature (Client’s Parent/Guardian if under 18) Date

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*Private insurance companies and governmental insurance programs such as Medicare and Medicaid, require you to sign an assignment of benefits in order for us to bill your insurance company directly. Georgia State Law requires a signed patient consent to release medical information to your insurance company and any other practices cooperating in the delivery of your care.*

**ASSIGNMENT OF INSURANCE INFORMATION:**

I hereby authorize assignment of benefits and payment of my medical / mental health benefits to:

**Talking Solutions Anger Management and Counseling Center** for services rendered to myself and/or other dependents. I agree to be responsible for payment of any co-pay charges and any balance due to charges not covered by my insurance policy. I understand that co-pays are due at the time of service and any additional charges are due in full upon receipt of my first statement. I authorize refunds to my insurance company for any overpaid benefits.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

**AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION:**

I hereby authorize **Talking Solutions Anger Management and Counseling Center** to contact my insurance company directly to obtain coverage and payment information regarding my policy.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.

**Name (Printed)**

**Signature** **Date**