Dr. Tonjanika Jackson, LPC, CPCS

3633 Wheeler Road • Suite 100 • Augusta, GA 30909 • Phone 706.364.0252 • Fax 706.364.0269

CLIENT CONSENT FOR COUNSELING

Welcome to Jackson Counseling Services. The following pages of this document contain important information about my professional services and business policies. These forms are an important tool to assess your condition and determine appropriate treatment for you. Please read through this entire packet carefully and let me know if you have any inquiries. Filling these out prior to your visit will save valuable time at the office, hopefully resulting in a timelier visit with your provider. Failure to complete the forms could result in a delay of your appointment. Please keep in mind that when you sign this document, it is a representation of an agreement between us. In order for our providers to give you the best care possible, it is required that you bring a **current and valid Driver's License (or other official state/ federal ID)** and a **current and valid Insurance Card(s) to your visit**.

COUNSELOR QUALIFICATIONS

I have been practicing within the Mental Health Counseling field for over 24 years. I am a Licensed Professional Counselor and a Certified Professional Counselors Supervisor. I am also a Certified Co-Occurring Disorder Professional Diplomat via the Alcohol and Drug Certification Board of Georgia and a Certified Professional Counselors Supervisor with the LPCA of Georgia. My areas of expertise include treating depression, anxiety, substance use disorders, trauma/recovery/PTSD, personality disorders, and conduct related disorders. I have also worked with clients who may need assistance with ADHD, ODD, self-esteem related issues, educational counseling (i.e., educational needs regarding failing grades, school related anxiety, collaborating with school systems during the response to intervention process, and the 504/Individualized Educational Plan processes). I also have experience conducting workshops and training on a variety of topics related to mental health, substance abuse, and education. I have a Master of Science Degree in Counseling Psychology, an Educational Specialist degree in Leadership, and a Doctorate Degree in Psychology. I am also a Certified Educator in the state of Georgia.

COUNSELING SERVICES

Counseling is not easily described in general statements. It varies depending on the personalities of the Counselor and the Client, and the particular problems for which you are seeking assistance. There are many different methods I may use to deal with the problems that you hope to address. Counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Counseling can have benefits and risks. Since counseling often

involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, counseling has also been shown to have benefits for people who go through it. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to continue with counseling. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Counseling involves a commitment of time, money, and energy, so you should be very careful about the counselor you select. If you have questions about my procedures, we should discuss them whenever they arise. If you decide you would prefer to see another Counselor or if I determine that I am not the best person to assist you, I will be happy to assist you with finding another mental health professional.

PSYCHOTHERAPY COSTS

Psychotherapy sessions are generally 53 to 60 minutes in length. Longer sessions may be arranged for patients who are self-paying and not limited by session lengths set by their insurance plan. If this is something you are interested in, please notify me in advance of the session to make arrangements. The **cost for a psychotherapy session is $165.00**, unless there have been prior arrangements made in writing by me. There is no provision for sliding scale fees of insurance-reimbursed psychotherapy sessions or waiver of copays due to laws enacted by insurance companies. Please read the information in this packet on Billing Procedures for further information regarding insurance and cancellation policy.

LENGTH OF TREATMENT

This depends in part on your specific needs and abilities, the goals we set together, and the involvement of your insurance company. Some Managed Care Organizations may limit the number of psychotherapy sessions per year. It is important that you know what your insurance company allows and that this be managed wisely. You have the right to terminate therapy at any time you choose. I would hope that you would allow me to participate in the termination decision rather than just disappearing as this deprives us both of the opportunity for feedback and closure.

The **PREPARE/ENRICH** premarital counseling program is typically completed in approximately 8 hours of counseling. The course of career and educational counseling is often briefer compared to the psychotherapy process. See the separate form which describes the differences between the different types of counseling services I provide.

CONFIDENTIALITY

Confidentiality in the counseling process is extremely important to me. In general, the privacy of our communications is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions:

1. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.
2. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, Georgia and South Carolina laws require me to file a report with the appropriate state agency.
3. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking

hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek a medical professional's assistance with hospitalization for him/her or to contact family members or others who can help provide protection.

4. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The Consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.
5. For clients under eighteen years of age, the law allows your parent/guardian access to information about your counseling with me. It is my practice to request your parent/guardian agree to receive only general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.
6. If your therapy is covered by insurance, they may request information about your condition and treatment. If your benefits are handled by a managed care company, they may require periodic information in order to authorize sessions. There is no confidentiality between myself and the insurance/managed care company. Once the information leaves my office, I am no longer responsible for the confidentiality of your records. If a collection agency must be used, they will receive only your name, address, and amount owed.
7. If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon request, furnish copies of all medical reports and bills.
8. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

COMMUNICATION POLICY

E-mail, mobile phone text messaging (SMS) and facsimile are not secure media for communicating with me about confidential counseling related issues. Therefore, confidentiality of e-mail and facsimiles cannot be guaranteed. Urgent or emergency communications should not be sent via email or fax since the timeliness of response to a facsimile or email message cannot be guaranteed. Social media such as Facebook, LinkedIn, Twitter, etc. are not appropriate means of communication with me as those media may compromise your confidentiality and privacy and blur the boundaries of the professional counseling relationship. Friend or contact requests sent to me by current clients, and some former clients, will not be accepted. I do not typically communicate with patients via email since that is typically not a secure and confidential means of communication. If you and I do choose to communicate via email, discussion about counseling session content should not be included. Those issues need to be discussed face to face or by phone communication in order to protect your privacy.

EMERGENCY PROCEDURE

If you have an emergency during the day, please telephone the office, inform them that this is an emergency, and I will call you as soon as I am free between client sessions. This contact will necessarily be brief and will be used to determine a course of action only. If you are in need of emergency assistance after hours, please call the main office number and you will be given instructions. If the emergency is critical and you are unable to reach me in a timely manner, then it is your responsibility to telephone 911 or have someone safely transport you to a hospital emergency room. When I am out of town or otherwise unavailable, I will be using the services of a colleague to handle emergency situations. Telephone calls that are not an emergency are usually returned after hours or at the latest by the following morning. Please leave a day and evening number where you can be reached. Please inform me if you are already being followed by a psychiatrist. A psychiatrist or other medical doctor is the only professional who can prescribe medications and they may be needed to assist with a hospital admission.

CLIENT RESPONSIBILITY

The following are your responsibilities as a client: If you are late for your appointment, then I reserve the right to reschedule your appointment if I believe your late arrival will inhibit my ability to provide a complete intake or counseling session or if I believe seeing you late will compromise my ability to honor my next client's appointment time. In some cases, I may be able to see you after arriving a few minutes late. But, be advised your late arrival will cause you to miss out on your complete session time. If I am late for your session, I will make the time up at the end of the hour in order to ensure you have your full session time. Please honor the 24-hour cancellation notice policy so that the time may be utilized by someone else, and you are not billed for an unused hour. You are expected to pay your bill as I have financial obligations to my office, my staff, my family, and myself. Talk with me if you are having difficulty with this.

- **Information**: The client must provide true, accurate, and complete information.
- **Instructions**: The client must follow instructions for treatment. The client should understand the consequences of not doing so, and if unable to comply, must inform the staff or me so that efforts can be made to help.
- **Refusal of Treatment**: The client and family are responsible for the outcomes if they do not follow the medical plan of treatment and discontinue treatment against advice.
- **Respect and Consideration**: Clients and family must show consideration for other clients and staff by helping to control noise and behaviors in the waiting room. **Cell phones are to be turned off in the waiting room.** You may step outside to use your cell phone. Clients and family must respect the property and privacy of others and the organization.
- **Obligations**: The client must keep appointments and fulfill financial obligations for their diagnostic and therapeutic services.
- **Behavior**: The client must abide by the rules and regulations of my office.

Not all services are a covered benefit in all insurance plans. Patients are expected to pay for any part of charges not covered by insurance. Unless prohibited by contract, patients will be billed for any unforeseen account balances after insurance has paid. A charge of **$25.00** will be assessed on all returned personal checks. Should your account be turned over to a collection agency, you will be responsible for collection fees, attorney fees, and court costs. If temporary financial problems affecting the timely payment of your account should arise, we encourage you to contact us promptly for assistance in management of your account.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record if you request it in writing, except in unusual circumstances that involve 1) danger to yourself and others, 2) that make reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, or 3) where information has been supplied to me confidentially by others. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded directly to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of $1.00 per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others), which I will discuss with you upon request.

AUDIO / VISUAL RECORDING

There is to be no use of any type of visual or auditory recording devices at any time without the knowledge and consent of all parties present, including the therapist.

CANCELLATION/NO SHOW POLICY

You are expected to remember your appointments whether or not our office staff is able to contact you with a reminder call. Appointments must be canceled at least 24 hours prior to the scheduled time, or you will be charged. If an emergency prohibits you from providing the 24-hour notice, this should be the exception rather than the rule. You may be required to provide written documentation of the emergency to prevent you from being billed.

Patient/Custodial Parent/Legal Guardian's Signature **Date**

PATIENT INFORMATION

PATIENT'S NAME:

_____

LAST FIRST MIDDLE

ADDRESS:

_____

_____

CITY STATE ZIP CODE

Home Phone: (____)____-_____ Work Phone: (____)____-_____ Mobile Phone: (____)____-_____

Email: _____ Preferred Contact (choose one):

Height: _____ Weight (lbs): _____ Age: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Preferred Sex/Pronouns: _____ Marital Status (choose one):

Family Physician Information:

Physician's Name/Practice: _____

Office Phone: (____)____-_____ Fax Number: (____)____-_____

ADDRESS:

_____

_____

CITY STATE ZIP CODE

Employment Information:

Place of Employment: _____ Occupation: _____

EMPLOYER'S ADDRESS:

_____

_____

CITY STATE ZIP CODE

Emergency Contact Information:

Contact's Name: _____

Contact's Phone: (____)____-_____ Relationship to Patient: _____

ADDRESS:

_____

_____

CITY STATE ZIP CODE

For Married Patients

Spouse's Name: _____ Date of Birth: _____/_____/_____

SSN: _____-_____-_____ Work Phone: (____)____-_____

Spouse's Employer: _____ Occupation: _____

If Patient is a Minor

Parent/Legal Guardian Name: _____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____

ADDRESS:

_____

_____

CITY STATE ZIP CODE

Place of Employment: _____ Work Phone: (____)____-_____

EMPLOYER'S ADDRESS:

_____

_____

CITY STATE ZIP CODE

Insurance Information

Primary Insurance Company:

Address: _____ Phone: _____

Policy Holder's Name: _____

Patient's Relationship to Policyholder (circle one): Self Spouse Child Other

Policy/Contract ID #: _____ Group Name/#: _____

Employer: _____

Patient's Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Secondary Insurance Company:

Address: _____ Phone: _____

Policy Holder's Name: _____

Patient's Relationship to Policyholder (circle one): Self Spouse Child Other

Policy/Contract ID #: _____ Group Name/#: _____

Employer: _____

Patient's Date of Birth: _____/_____/_____ SSN: _____-_____-_____

IMPORTANT INSURANCE NOTICE

We do not guarantee insurance benefits or insurance payments. We also do not guarantee that a provider is in-network for any patient's plan. We request all patients to contact their individual insurance company to verify benefits and provider network status before their appointment.

Please sign acknowledgement of this information.

Signature **Date**

Insurance Informed Consent

By signing this Patient Informed Consent and Authorization as the patient or guardian of said patient, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I am voluntarily agreeing to receive mental health assessment, treatment, and services, from Dr. Tonjanika Jackson, LPC, CPCS, for me (or my child if said child is the patient).

I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my/their health insurance. Deductibles and copayments will be made at the time services are rendered.

Patient/Custodial Parent/Legal Guardian's Signature **Date**

***Please give the receptionist your insurance card at the time of check-in. If you have two insurance companies, please inform us at your first visit.**

EMAIL AND TEXT MESSAGING CONSENT FORM

I, _____ authorize _____ to send
(Patient Printed Name) (Therapist Name)
automated appointment reminder email and/or text messages to me. I understand my therapist is not responsible for any breach of privacy, confidentiality, or security of the emails/texts once they are received on my electronic devices. I understand the reminder system is automated, accepts replies to emails/texts, and is used for the sole purpose of appointment reminders. I agree to call the Clinicians Office at (706)364-0252 within regular business hours to cancel/reschedule appointments. I understand I may be charged a late cancellation/no show fee if I do not honor the 24-hour cancellation notice policy. In the case of an emergency, I agree to notify the office as soon as possible.

Contact by text messages:

- ☐ I DO wish to have this contact at the following phone number: (____)_____
- ☐ I DO NOT wish to have this contact.

Contact by email:

- ☐ I DO wish to have this contact at the following email address: _____
- ☐ I DO NOT wish to have this contact.

Patient/Custodial Parent/Legal Guardian's Signature **Date**

Assignment of Insurance Benefits

For the purpose of paying all or part of the fees owed to Dr. Tonjanika Jackson, LPC, CPCS for the services which have or will be rendered to the above patient, the undersigned hereby irrevocably assigns any insurance payments payable for the benefit of said patient by the above insurance company or companies and all rights and interest in said policy, but only to the extent necessary to pay Dr. Tonjanika Jackson, LPC, CPCS, as a result of rendering services to the above mentioned patient whose liability will be reduced by the amount of benefit payments received hereunder. Undersigned understands that the nature of the patient's disability may be such that no benefit payments will be payable under the policy specified above. Any fees owed by the undersigned under the terms of this agreement shall be paid in full within thirty days after billing agency unless prior arrangements have been made in writing with Dr. Tonjanika Jackson, LPC, CPCS.

Patient/Custodial Parent/Legal Guardian's Signature **Date**

Consent for Disclosure of Information to Third Party Payers (Entities that pay your claims)

The undersigned authorizes Dr. Tonjanika Jackson, LPC, CPCS to release all patient information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the patient is being evaluated and treated, to the insurance company, the third party payer, or its representatives.

The undersigned acknowledges that such disclosures shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the insurance company or third party payer.

The undersigned understands that the information obtained by use of this "Authorization" may be used by the above mentioned insurance company or third party payer to determine eligibility for benefits under an existing policy, and further understands that information obtained by such insurance company or third party payer shall not be released to any other person unless the undersigned so authorizes.

The undersigned acknowledges that he/she may request to receive a copy of this Authorization for disclosure of information to third party payers, and that he/she may revoke this Authorization at any time, except to the extent that action has been taken in reliance thereon.

The undersigned further acknowledges that this Authorization shall be valid during the pendency of these claims.

Patient/Custodial Parent/Legal Guardian's Signature **Date**

Client Information and Informed Consent for Telemental Health Treatment

Telemental health services involve the use of electronic communications (telephone, video conference, etc.) to enable therapists to provide services to individuals remotely. Telemental health is a relatively recent approach to delivering care and there are some limitations compared with seeing a therapist in person. These limitations can be addressed and are usually minor depending on the needs of the client and the care with which the technology (cell phone, tablet, computer, etc.) is utilized.

Additional Points for Client Understanding:

- I understand that telemental health services are completely voluntary and that I can choose not to do it or not to answer questions at any time.
- I understand that none of the telemental health sessions will be recorded or photographed by my therapist without my written permission, and I understand that I may not record or photograph any of my telemental health sessions without the written permission of my therapist.
- I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.
- I understand that because this is a technologically based method it may sometimes be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
- I understand mental health is performed over a secure communication system that is almost impossible for anyone else to access, but because there is still a possibility of a breach, I accept the very rare risk that this could affect confidentiality.
- I understand that there are risks from telemental health that may include but are not limited to the possibility despite all reasonable efforts by my provider: the transmission of medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings may occur more easily, particularly when care is delivered in an asynchronous manner.
- I understand that telemental health sessions will not be the same as an in-person session since I will not be in the same room as my therapist.
- I understand that I may experience benefits from the use of telemental health in my care, but that no results can be guaranteed or assured.
- I understand I am responsible for creating a safe, confidential space during sessions and I will engage in sessions in a private location where I cannot be heard or seen by others.
- I understand I am responsible for logging out or hanging up once sessions are complete.
- I understand you may contact me from a blocked number to avoid others knowing we have connected.
- I understand that if there is an emergency during a telemental health session, then my therapist will call emergency services and my emergency contact. I understand that if I do not follow safety/emergency protocols, my therapist has the right to discontinue use of teletherapy to protect my safety and well-being.
- I understand that if the video conferencing or telephone connection drops while I am in a session, I will provide a phone number (see below) for follow up contact if a plan for technical failures has not already been arranged with my therapist.
- I understand that I am required to provide an emergency contact (see below) in case of an emergency.
- I understand that telemental health-based services may not be appropriate for everyone seeking therapy. In person therapy may be deemed necessary by my therapist.
- I understand I may be requested to install applications specific to treatment onto my phone, tablet, or computer device. Some applications specifically interact via phone /tablet, device, etc. and have the capability to report activity, GPS location, etc.

- I understand I have the right to withhold or withdraw this consent at any time. However, if I do so, this may require my therapist to provide referrals to other treatment providers if face-to-face services are not an option based on geography and/or circumstance.
- I understand the laws that protect the confidentiality of my personal health information also apply to telemental health, as do the limitations to that confidentiality discussed in the *Client Consent for Counseling* agreement. I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction will not be shared without my written consent.
- I understand that email is not an appropriate means of communicating with my therapist in the case of an emergency. I understand the email address provided below is to be used for providing this form only and is not an email that is monitored by my therapist. Any email address used by my therapist to engage in video conferencing is also not meant to be used in the case of an emergency or for counseling related content to be shared. I understand that email is not a secure communication medium for sensitive/personal information. I agree to call the office for scheduling, payments, insurance questions, or supplying other information.
- I understand that it is my responsibility to call and make payment for any balance due at the conclusion of my telehealth session.

Emergency Contact Name: _____ Emergency Contact Number:(___)___-_____

CANCELLATION/NO SHOW POLICY

If you need to cancel an appointment, please follow the same procedure you already agreed to in the *Client Consent for Counseling* documents. **As a reminder, cancellations should be made within 24 hours of your scheduled session time, unless you have a same-day emergency to arise.** Please call and inform our office of any same-day emergencies. **If cancellation is not made within 24 hours, I reserve the right to charge a $75 fee in the same way a fee is charged for missing or late canceling in-person sessions.**

PAYMENT FOR SERVICES

As with your in-person sessions, we will submit a claim to any insurance provider you gave us written consent to bill in your *Consent for Disclosure of Information to Third Party Payors*. Not all mental health services are a covered benefit in all insurance plans. If you are unsure of coverage, please contact your insurance company. **Patients are expected to pay for any part of charges not covered by insurance per usual procedure (i.e., copay, deductibles, etc.).** Billing processes are the same for telemental health services as with in-office visits, as outlined in the Client Consent for Counseling document. Self-pay arrangements already in place will remain the same for teletherapy sessions. **Please call the office to make a payment by/at the conclusion of your session.**

CONSENT

I consent to engaging in telemental health as part of my treatment with Dr. Tonjanika Jackson. I understand that "telemental health" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of personal health information, and education using interactive audio, video, or data communications. I understand the information provided above regarding telemental health. I hereby give my informed consent for the use of telemental health in my care.

Patient's Name (Print): _____

Email: _____ Mobile Phone: (____)____-_____

Patient's Signature **Date**

Legal Guardian's Name [if patient under 18] (Print)

Legal Guardian's Signature **Date**

INFORMED CONSENT FOR IN-PERSON SERVICES AND COVID

Decision to Meet Face-to-Face

There may be a need to meet in person for some or all sessions. If there is a resurgence of COVID or if other health concerns arise, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for both of our well-being. If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, if it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service. Your Responsibility to Minimize Your Exposure To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, our staff, our families, and other patients) safer from exposure, sickness, and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each point below to indicate that you understand and agree to these actions:

- Face masks are currently optional. You may wear a mask in the office if you choose. _____
- The waiting room should be limited to patients being seen for therapy sessions. Minor patients or patients needing physical assistance may bring 1 person with them into the waiting room. Please contact the office if this creates a problem for you. _____
- You will take steps between appointments to minimize your exposure to COVID. _____
- If you have a job that exposes you to other people who are infected, you will immediately inform me/office staff. _____
- If you or a resident of your home tests positive for the infection or have been symptomatic from COVID within the last 10 days, you will immediately let me/office staff know and we will then [begin] resume treatment via telehealth. _____
- I understand that my therapist cannot be held responsible for any exposure risks outside of the therapy office in other parts of the building or the parking lot. _____

I may change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

If You or I Are Sick

You understand that I am committed to keeping you, me, my staff, and our families safe from the spread of this virus. If you show up for an appointment and I, or my office staff, believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I, or my staff, test positive for the coronavirus and may have exposed you, I will notify you so that you can take appropriate precautions.

Informed Consent

This agreement supplements the general informed consent/business agreement.

Your signature below shows that you agree to these terms and conditions.

Signature **Date**

BILLING PROCEDURES

- Appointments must be canceled at least 24 hours prior to the scheduled appointment or you will be charged a **"No-Show" or late cancellation fee** of **$75.00**.
- A charge of **$25.00** will be assessed on all returned personal checks.
- Insurance will be filed for your appointments after the office has verified insurance coverage.
- Insurance deductibles, copayments, and coinsurance amounts must be met at the time of service.
- Insurance laws have been enacted that forbid fee altering for services. If you have hardship needs, please discuss this with me during our first session.
- Statements are mailed on a monthly basis.
- I accept checks, cash, debit cards, and credit cards (i.e., Visa, MasterCard) as forms of payment.

Please direct any concerns or questions to either myself or the receptionist at 706-364-0252.

Please sign to indicate that you have read and understand my billing policies. If you do not understand, please inform me during our first session.

Patient/Guarantor's Signature **Date**

Whom may we thank for referring you to us? _____

****WOULD YOU LIKE INFORMATION RELEASED TO YOUR PRIMARY CARE PHYSICIAN?**

- ☐ YES (COMPLETE ALL INFORMATION BELOW – SIGN & DATE)
- ☐ NO (**PLEASE SIGN & DATE AT THE BOTTOM)

Client's Name: _____ Date of Birth: _____

Primary Care Physician Information:

Physician's Name/Practice: _____

Office Phone: (____)____-_____ Fax Number: (____)____-_____

ADDRESS:

_____

_____

CITY STATE ZIP CODE

I, _____, authorize Dr. Tonjanika Jackson, LPC, CPCS and my primary care physician, Dr. _____ to exchange information regarding my mental health and/or substance abuse treatment and medical health care for coordination of care purposes as may be necessary for the administration and provision of my health care coverage. The information exchanged may include information on mental health care and/or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for 12 months from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral health provider. I also understand that it is my responsibility to notify my behavioral health provider if I choose to change my primary care physician.

_____

Signature **Date**

THANK YOU *for taking the time to fill out this packet prior to the scheduled time of your appointment. Please bring this completed form with you to your appointment after having received it from the office or plan to arrive a minimum of 30 minutes early for your appointment in order to complete the paperwork in the office. This information will be used by your Counselor to provide you with the best possible counseling services. If you are uncomfortable answering any of this information or have questions about this form, please leave those questions blank and your Counselor will discuss it with you. All information will be kept confidential, subject to the exceptions noted in the previous Client Consent for Counseling Form.*

PERSONAL INFORMATION FOR YOUR COUNSELOR

PATIENT'S NAME:

_____

LAST FIRST MIDDLE

Preferred Name/Nickname: _____ Date of Birth: _____/_____/_____

Age: _____ Preferred Sex/Pronouns: _____

Ethnicity (choose one): Religion/Spiritual Orientation: _____

A. EMPLOYMENT/SCHOOL

Occupation, employer, and number of hours worked per week:

_____

Highest Level of Education Achieved:

_____

Are you in school/college now?

- ☐ Yes
- ☐ No

If yes, please state where?

_____

Grade or year in college/graduate program: _____

College major/graduate program: _____

B. MARITAL/PARTNERSHIP AND HOME INFORMATION

Relationship Status:

- ☐ Single
- ☐ Committed Relationship (How long?) _____
- ☐ Engaged (When?) _____
- ☐ Separated (When?) _____
- ☐ Divorced (When?) _____
- ☐ Married (1st marriage? Yes or No When?) _____
- ☐ Widowed/Widower (How long?) _____

Sexual orientation: _____

If you have children, list your children and their ages:

_____

_____

_____

List who resides with you and indicate relationship:

_____

_____

_____

C. CURRENT NEEDS /TREATMENT HISTORY

Briefly describe the reason(s) you are seeking services at this time.

_____

_____

_____

_____

How long have you been concerned about the problems that bring you to counseling now?

In what ways have you attempted to work on these problems so far?

How much counseling or psychotherapy have you had in the past?

- ☐ None
- ☐ <1 month
- ☐ 1-3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ More than 1 year

Describe the counseling:

Are you currently seeing another counselor, psychologist, or psychiatrist?

- ☐ Yes
- ☐ No

If yes, list name of clinician and their office contact information:

Family/Primary Care Physician Name: (Name, Address & Phone)

Describe any medical conditions/health problems:

Please list all medications (both psychiatric and non-psychiatric) you are currently taking, the dosage, and name of the physician who prescribed it:

Name: _____ Dose: _____ Prescriber: _____
Start Date: _____ Reason: _____

Name: _____ Dose: _____ Prescriber: _____
Start Date: _____ Reason: _____

Name: _____ Dose: _____ Prescriber: _____
Start Date: _____ Reason: _____

Name: _____ Dose: _____ Prescriber: _____
Start Date: _____ Reason: _____

Name: _____ Dose: _____ Prescriber: _____
Start Date: _____ Reason: _____

If you have ever taken any **other** medications (other than those listed above) for problems related to stress, anxiety, depression, sleep, or any other medication related to an emotional issue list name of medication(s), when you took it, the purpose of the medication, and if you found the medication helpful:

_____

_____

Do you **currently** have suicidal feelings? _____ Have you been suicidal **in the past**? _____
If yes to either, please explain:

_____

_____

Any past hospitalizations related to mental health, attempted suicide, or alcohol/substance abuse?

- ☐ Yes
- ☐ No

If yes, please explain:

_____

D. SUBSTANCES

What is your history with the following substances?

Alcohol:
Quantities/Frequency in Past: _____
Quantities/Frequency Now: _____

Street/Recreational Drugs (please specify drug & frequency of use):
Quantities/Frequency in Past: _____
Quantities/Frequency Now: _____

Nicotine:
Quantities/Frequency in Past: _____
Quantities/Frequency Now: _____

E. FAMILY/PERSONAL HISTORY

Is there a diagnosed or suspected family history of psychological problems?

- ☐ Yes
- ☐ No

If yes, describe who & what problem:

Did either parent have a problem with alcohol or other drugs?

- ☐ Yes
- ☐ No

If yes, who? _____

Are your parents still together?

- ☐ Yes
- ☐ No

If no, how old were you when their relationship ended? _____

Do you believe you experienced physical abuse?

- ☐ Yes
- ☐ No

If yes, who was the source of the abuse and when? _____

Do you believe you experienced verbal or emotional abuse (i.e., name calling, criticism, being ignored)?

- ☐ Yes
- ☐ No

If yes, who was the source of the abuse and when? _____

Have you had an unwanted sexual experience as a child or as an adult?

- ☐ Yes
- ☐ No

If yes, by whom? _____

How old were you when this occurred ? _____

Did you tell anyone?

- ☐ Yes
- ☐ No

Have you ever served in a branch of the U.S. military?

- ☐ Yes
- ☐ No

If yes, did your service include a combat tour of duty?

- ☐ Yes
- ☐ No

If yes, describe:

_____

_____

Do you experience problems related to any past very stressful event(s)? (i.e., nightmares, thinking about events when you do not want to, going out of your way to avoid reminders of past events, feel constantly on guard, watchful or easily startled, feel guilty or unable to stop blaming yourself/others for past events, feel numb or detached from outside world)

- ☐ Yes
- ☐ No

If yes, what event(s) do you believe is the source of these problems?

_____

_____

Please describe the quality of the relationship with your **mother**:

_____

_____

Please describe the quality of the relationship with your **father**:

Please describe the quality of the relationship with a **stepparent**: (specify if stepmother/stepfather)

Please describe the quality of the relationship with your **spouse/significant other**:

Please list ages of **siblings** and note the quality of your relationship:

Please make any other comments here you wish (i.e., any strengths or unique qualities about you that could inform our work together, what you are looking for in a therapist, fears about starting therapy, your hopes for the future, etc.).

PERSONAL SAFETY/CRISIS PLAN

Individual's Name:_____ Date of Birth: _____/_____/_____

Date of Personal Safety/Crisis Plan:_____/_____/_____ Initiation of Services: _____

1. People that participate in therapy sometimes experience one or more of the following conditions:
    - Self-harm (thoughts/feelings/behaviors to hurt, cut, hit, burn, etc. oneself)
    - Aggression (thoughts/feelings/behaviors to hurt, break things, threaten, cut, hit, burn, etc. others)
2. If you ever experience such thoughts, feelings, or behaviors, this document is a Safety/Crisis Plan with an attached Self-Care Plan intended to help you if you ever find yourself having any of the above-mentioned thoughts/ideas.

Part I: Please answer the following questions as honestly as you can, so that we can help provide a safe environment if you ever find yourself experiencing thoughts of harming yourself or others.

Some things I notice about myself or what others may notice when I begin to lose control:

Some things that make me upset or angry, my "triggers" are?

I can do or tell myself these things to calm down:

Someone I can talk to about my thoughts and feelings when I feel out of control is:

Have I ever had thoughts about hurting myself or anyone else in the past?

If I have thoughts about hurting myself or anyone else, I will:

If I am alone and have thoughts and feelings about hurting myself or someone else, I will:

Part II: Self-Care Plan

1. If, at any time, I should feel unable to resist impulses to self-harm, to act-out aggressively, or to engage in harmful behaviors, I agree to do several of the following options:
    a. Self-care activities:

b. Agency and Professionals that serve as my primary point of contact when I am experiencing a crisis are the following:
    - Georgia Crisis and Access (GCAL) Line Phone: 1-800-715-4225 or 988

c. Call a relative, friend, or sponsor:
   Name: _____ Phone: _____
   Name: _____ Phone: _____
   Name: _____ Phone: _____
   Name: _____ Phone: _____

Additional Crisis Lines and "warm" lines you can reach:

d. Call Lighthouse Care Center of Augusta 706-651-0005
e. Call Medical College of Georgia at GRU 706-721-3141
f. Visit a local Emergency Room
g. Call 911 or Call 988
h. Peer Support and Wellness Center 888-945-1414
i. Teens in crisis hotline at 877-968-5463

2. This Self-Care Plan begins immediately and will remain in effect for the duration of your therapy with **Dr. Tonjanika Jackson, LPC, CPCS**, as well as updated as needed per clinician or by your choice. Your agreement to this plan shows that you are committed to work through any thoughts, feelings, and behaviors at this time as well as in the future.

3. By signing this document, you are agreeing to the following statements and actions:
    a. I understand that there are people available to help me.
    b. I also understand that getting the help and assistance I need might take some time.
    c. I agree not to do anything to harm myself or others in any way while I am seeking out help and assistance. This includes any kind of overt or passive acts of danger to myself or others.
    d. Overt acts are intentional acts to harm myself or others. Passive acts involve putting myself or others in possible danger, such as not looking when crossing a street or engaging in unprotected sexual activities.

4. Your signature below indicates that you have read and understand what is being asked of you, and you are choosing to agree to uphold this Self-Care Plan without exception.

Individual's Signature **Date**

Parent/Guardian's Signature (if applicable) **Date**

Therapist's Signature **Date**

Please cut below to keep the wallet-size Self-Care Plan with you at all times:

SELF-CARE PLAN (please keep in your wallet)

- Self-Care activities:

  _____

  _____

  _____

- Call a relative, friend, or sponsor:
  - Name: _____ Phone: _____
  - Name: _____ Phone: _____
  - Name: _____ Phone: _____
  - Name: _____ Phone: _____
- **Your therapist: Dr. Tonjanika Jackson, LPC, CPCS**
- **Contact number: 706-364-0252**
- Georgia Crisis and Access (GCAL) Line Phone: **1-800-715-4225** or **988**
- Call Behavioral Health Link/GCAL: **800-715-4225**
- Call Lighthouse Care Center of Augusta: **706-651-0005**
- Call Medical College of Georgia at GRU: **706-721-3141**
- Visit a local Emergency Room
- **911** or **988**