Linda Winship, LCSW
Taylor Hagin, NCACII, CACII
1260 Concord Road, Suite 201
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770-436-2025 (phone or fax)
L.WinshipLCSW@comcast.net

Patient Information

Today's Date _____/_____/_____ Referred by _____

Patient's Last Name _____ First Name _____ M.I. _____

Date of Birth _____/_____/_____ Sex ____ Marital Status _____ Soc. Security # _____

Address _____

_____
City State Zip Code

Home Phone _____ Work Phone _____ Cell _____

(Please indicate if you have a preferred phone for me to call) Email _____

Employer _____

Policy-Holder Information (if different from Patient)

Last Name _____ First Name _____ M.I. _____

Relationship to Patient _____

Date of Birth _____/_____/_____ Sex _____Marital Status _____Soc. Security # _____

Address _____

_____
City State Zip Code

Home Phone _____ Work Phone _____ Cell _____

Employer _____

Insurance Information

Insurance Company _____ Customer Service Phone # (____)_____

Primary Care Physician's Name _____Phone _____

Group # _____ Policy #_____

Claims Address _____

_____
City State Zip Code

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Office Policies and Procedures

This information sheet is designed to orient you to office policies and procedures. I will be happy to discuss questions and concerns with you.

OFFICE HOURS: Hours vary daily from Monday through Saturday. Limited evening and Saturday hours are available. I will inform you of holidays and vacations in advance.

SCHEDULING: Office visits are by appointment only. I will schedule appointments personally and ask for 24 hours' notice for cancellations. This courtesy avoids your being charged for a missed appointment and allows me to give another person the time. YOU WILL BE CHARGED FOR APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE. Messages regarding cancellations may be left on my voicemail.

FEES AND INSURANCE: I am a member of many insurance company panels, the contracted rates for which I do accept. However, final responsibility for services ultimately rests with the patient. Please discuss your needs or concerns with me initially. There will be a $25 charge for returned checks. By signing below, you will authorize payment of medical benefits directly to me.

RELEASE OF INFORMATION: Most managed care companies require some clinical information to support reimbursement, including a diagnosis and a written treatment plan. Unless you decline your benefits, I will release information required by your insurance.

EMERGENCIES: I check my messages several times daily. There will be times, however, when I can't get back with you right away. You may call me on my cell phone (770-713-5596) for emergencies, though I do ask that you not call that number me for other than an urgent situation. If you have an acute crisis and can't reach me, go immediately to the nearest emergency room.

* *

I have read, understand, and am willing to comply with the above policies and procedures.

_____ _____

Signature Date

Client Rights and Responsibilities

Client Rights

Confidentiality - In general, whatever you say to your therapist is confidential and privileged information, which means that you control any release of that information. In cases of life-threatening emergencies, possible child abuse, or a court order, the therapist may have a duty to give specific information to specific persons.

Informed Consent – You have the right to an explanation of your condition and treatment in language that you can understand. You have the right to consent or agree to treatment, and you also have the right to refuse treatment. If you do not consent to treatment, this does not affect your rights under the law.

Participation in Your Own Treatment – You have the right to participate in planning and implementing your own treatment, including choosing among treatment options. You also have the right to file complaints regarding your treatment.

Respect and Non-Discrimination – You have the right to be treated with respect and dignity by your therapist. You have the right to equal treatment, regardless of your race, ethnic origin, religion, creed, gender, age, disability status, sexual orientation, or source of payment.

Other Information and Options – You have the right to professionally-relevant information regarding your provider. You also have the right to know about treatment options, regardless of the cost or if they are covered by insurance. You can obtain information about all your rights under Georgia law and under the rules governing the profession by contacting the State licensing board (912-207-1670).

Client Responsibilities

Fee Payment – You are financially responsible for your treatment, as noted in the attached page of office policies and procedures.

Participation in Treatment – In order to benefit from treatment, you must participate by providing your therapist with full information related to the treatment, following therapeutic advice and directions – including taking any medications as prescribed, and completing homework assignments. You should also ask for information on any aspect of the treatment you do not understand, and inform your therapist whenever therapy does not seem to be working for you.

Respect – You are responsible to treat you therapist with respect and dignity. Safety – You are responsible for avoiding any actions that could harm yourself or someone else, and collaborating in actions your therapist might take in the interest of safety.

Timely Notification – You are responsible for telling your therapist of any changes in address, phone number, insurance coverage, and other information that enables your therapist to contact you when necessary, and to facilitate accessing your insurance benefits.

My signature below certifies that I have been informed of my rights and responsibilities, and that I understand this information. I understand that it is my sole responsibility to request clarification or additional information concerning my rights and responsibilities. I can have a copy of this document upon request.

_____ _____

Client's Signature Date

The signature below certifies that I have explained these rights and responsibilities, using language that is understandable to this client. I have offered this client a copy of this form.

_____ _____

Therapist's/Counselor Signature Date