Edward Clark, LPC, CCADC, CTP
5445 McGinnis Village Place, Suite 103
Alpharetta, GA 30005
678.982.9039 office
ed@lifefocus.biz

Registration Form

Client Name:_____ D.O.B:_____
Male_____ Female_____ (circle): Single, Married, Widowed, Separated, or Divorced
Home Address:_____
City_____ State_____ Zip Code_____
Cell Phone: _____ Other Phone: _____
Email:_____ Referred by _____
Employer:_____
Occupation: _____ Work Phone: _____ Ext_____
Children and other Household members (names and ages):
_____
_____
Spouse/Parent:_____ Age_____
Address (if different): _____
Cell Phone:_____ Other Phone:_____

Name, Address and Phone Number of Primary Care Physician or Psychiatrist:
_____
_____

Appointment Cancellation Fee
I hereby give consent and authorization to Life Focus, Inc. to collect a $100.00 fee for any missed appointment or failure to cancel any appointment at least 24 hours prior to any appointed session time. If you do not wish to provide a credit card to be kept on a file, a $100.00 deposit (cash or check that will be deposited) will be required. See Office & Confidentiality Policy for details.

Name on Debit/Credit Card (Print Name): _____
Card number:_____Exp date:_____/____ CVV_____
Please Circle: MasterCard Visa Amex Discover Other:_____

What is the relationship between the client & the name on card? (if different)
Circle one: Self Parent(s) Spouse Sibling Other: _____

All credit card information is strictly kept confidential.
All questions regarding financial responsibility should be discussed with your therapist prior to the session. ***I hereby agree to and attest that the above information is accurate and true:***

Client Signature(s):_____ **Date:**_____

Client Name (Print):_____ **Date:**_____

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Office and Confidentiality Policy

Welcome to Life Focus, Inc. We hope our services bring you inspiration, hope and blessings. These written documents are provided to bring therapeutic boundaries, clarity of professional relationships, its limits and liabilities.

In signing these documents, you are making an agreement to several things including: giving permission for the provider to render services to yourself and/or your child(ren). You will be treated with respect and honesty; you also will expect to benefit from treatment but agree that there are no guarantees, and you acknowledge that maximum benefits will occur with regular attendance, but understand that you may occasionally feel temporarily worse in the course of the process.

Please read the following document carefully. It outlines the Policies and Procedures as they relate to our practice and the Rights and Responsibilities of our clients. Any questions you may have can and should be discussed in detail with your therapist during your first meeting. Your signature at the end of this document indicates that you have read, understood, agree and consent to these terms.

Professional Consulting and Confidentiality Policy

Life Focus, Inc. therapists may consult with other professional therapists and other medical practitioners in order to gain a better understanding and a different perspective of client issues they may encounter. The Life Focus, Inc. therapists will only reveal information that is relevant to your issue. In signing this document, you are giving consent for your therapist to speak with other professionals on your behalf.

Life Focus, Inc. will not disclose or confirm your use of services at this office, except as it is necessary for insurance reimbursement or an insurance audit. Lawful and legally required exceptions to this privilege of confidentiality include: information of child abuse, elder abuse, the immediate physical danger to yourself or another, a lawful court order and your signed consent.

Professional Relationship

According to the ethical standards of the profession, entering into a "patient-doctor" relationship enjoins special protections upon that relationship. This is necessary in order to protect the parties from potential conflicts of interest or abuse of power and it allows for greater freedom and security in the relationship within the therapeutic process. Intimate friendships and personal business (outside of the therapeutic relationship) are to be avoided between the therapist and client. In public, the therapist shall defer to the client regarding any acknowledgment of acquaintance. All acknowledgements of the relationship should reflect a casual relationship "I think we have met at a church function…etc." Any dual relationship between therapists and clients is highly discouraged. Only under special circumstances where there is third-party accountability and with full informed consent of all parties.

Appointments and Financial Responsibility

My fee for appointments 55-60 minutes in length is $175.00 for individuals and/or couples. All sessions that run over by 15-30 minutes will be billed an additional $87.50. There are no refunds for services that are prepaid; said monies will only be applied toward future scheduled services. Clients who prepay for services but fail to schedule an appointment for a period of 6 months or longer from the time of their last appointment forfeit any and all remaining prepaid monies. Payments for services rendered, including copayments and deductibles, are due at the time of service. All billed services are deemed "past due" and "payable in full" upon receipt of the statement. There will be an additional $35.00 fee charged to the client for Non-Sufficient Fund (NSF) charges for returned checks or declined charge cards at the time of payment. Clients may request credit or debit account numbers to be on file with Life Focus, Inc. and for said services to be charged. Please note the above-listed $35.00 fee applies to accounts on file as well.

In order to maintain the operation and continuation of our services, it has become necessary to hold each client responsible to guarantee payment for services rendered. Insurance companies will not guarantee payment for services rendered. Each appointment is set aside as a time reserved for you. No one else shall be entitled to that time. Therefore, when an appointment is missed without 24-hour notice, someone else has missed a crucial opportunity and the therapist cannot recover his/her time that was allocated to you.

***For New clients -** *New clients who make appointments but fail to cancel said appointment or reschedule at least 24 hours prior to the start of their allotted appointment will be required to place a $75 "appointment hold" on their next scheduled appointment. When the client makes their appointment, the "hold fee" will be applied to the session fee. If the client misses or reschedules their appointment (even if they reschedule at least 24 hours prior to their session) the "hold fee" is forfeited.*

As a client, you are responsible for keeping scheduled appointments. With the exception of true emergencies (documented hospitalization, car accidents, etc.) failure to provide a 24-hour notice to cancel will result in a "canceled or missed" appointment fee of $100, which must be paid before the next appointment can be scheduled. If you have a credit card on file, your credit card will be charged. If you do not provide a credit card number to keep on file, you will be required to provide a $100.00 deposit (in cash or check that will be deposited within one business day). The fee will only be utilized in the event you do not show up for an appointment or do not give a 24-hour notice for cancellation. If the deposit is utilized as mentioned above, you will be required to provide an additional $100.00 (cash or check) before setting up any additional appointments. The $100.00 can not be used towards the payment of a session. Your insurance carrier will not cover missed appointment fees. Failure to pay for a missed appointment will result in further scheduled appointments being canceled.

Legal and Clinical Fees

In order to provide the highest quality therapeutic services, clients may be asked to take an assessment instrument(s) to develop appropriate clinical goals, plans and direction in addressing clients' therapeutic needs. ***Each assessment instrument is an additional cost of $50.*** *There is a $175 fee for preparing clinical documents at the request of clients or their legal representatives. This fee is payable before work shall be done, the balance (if any) is due upon receipt of said document.* Please be advised, **your therapist will not testify** in court on your behalf unless court ordered to do so. Your therapist can give an objective assessment of the client and their therapeutic needs to court officials. A retainer fee of $500 is required before scheduling a court appearance date. An **48-hour notice** is required to cancel without loss of retainer. There is a $700 fee (minus retainer fee) for a

3-hour court appearance. There is an additional $175 per hour over the initial 3-hour limit. Any court delays or rescheduling by the court, is still the financial responsibility of the client.

Any questions regarding the preceding information can and should be discussed in detail with your therapist. Your signature below indicates that you have read and understand, agree and consent to these terms.

Client Signature: _____

Client Name (Print): _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

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PRE Counseling Evaluation Survey

Client Name: _____ Date: _____

Overall assessment of life condition (1= terrible to 10= great) 1 2 3 4 5 6 7 8 9 10

Please circle ALL that apply:

Indecisiveness	Nightmares	Heart palpitations	Feelings of inadequacy
Sleep problems	Anger/Outburst	Porn Addiction	Can't concentrate
Poor Boundaries	Regretful	Unloved	Worthlessness
Memory problems	Bored easily	Stomach troubles	Isolating from others
Fainting spells	Dizziness	Not confident	Feelings of hopelessness
Restlessness	Nervous	Perfectionistic	No/little motivation
Suicidal ideations	Depressed	Alcohol problems	Lack of confidence
Life feels empty	Headaches	Unable to relax	Financial problems
Feelings of anxiety	Workaholic	Not responsible	Relationship problems
Feeling guilty	Stressed	Inferiority feelings	Feelings of grief/loss
Marital problems	Panic attacks	Daydreams a lot	Feelings of loneliness
Sleeps a lot	Irritable	Negative thinking	Impulsive Behaviors
Low self esteem	OCD	Controlling	Poor school performance
Thinks too much	Problems w/child	Problems w/parents	Drug abuse/dependence
Overly sensitive to the opinions of others		Lacks empathy for others	

Other symptom(s):_____

a) Reason (s) for starting counseling:

__ I/We need help
__ Family and friends encouraged me to seek help
__ I just need someone to talk to
__ I was forced/coerced to seek help

b) Rate your diet/eating choices? 1 2 3 4 5 6 7 8 9 10 (1= terrible to 10=great)

c) Typical sleep hours _____ to _____

Post Counseling Evaluation Survey

Ending Date: _____ ( ) ***Client did not return to complete survey***

Current assessment of life condition 1 2 3 4 5 6 7 8 9 10 (1= terrible to 10=great)

Which symptom(s) decreased and by how much ? **(10%, 25% 50% 90%, etc**)

_____ _____% _____ _____%
_____ _____% _____ _____%
_____ _____% _____ _____%

Were you satisfied with the level of care you received? **Yes or No**, If no, please explain:

_____
_____
_____

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Book Loan/Return Policy
Nutritional Suggestion/Recommendation Disclaimer

Book Loan/Return Policy

Clients who are loaned any books or test materials from Life Focus, Inc. are to return said books or materials at the agreed upon time. Time extensions for the return of books and or materials will be discussed by both parties (as therapeutically necessary) before their due date. Any books or materials not returned, a request for their return will be made by phone, email or text. ***If the books or materials are not returned within 30 days after the agreed due date or in its original condition, the client must replace the book (better or equal condition) or they will be charged $35.00 per item.*** No further counseling appointments will be made until this matter is settled.

Nutritional Suggestions/Recommendation Disclaimer

Periodically, I will advise clients on the importance and effect of nutrition on various aspects of mental health. The Bible is very clear on maintaining our physical health, as well as our emotional, spiritual and psychological well-being. If our nutrition is out of balance, this may cause many physical issues that are often seen as emotional or other mental health problems. I may suggest nutritional supplementation along with a balanced meal plan to enhance and optimize the client's counseling and therapeutic results. I hold no certification nor degree in nutrition/dietary studies, All of my recommendations/suggestions are taken from published resources. ***I insist that each client consult with their primary care physician, dietician or certified nutritionist for approval, prior to beginning any nutritional plan discussed.***

By signing, the client understands and agrees with the above disclaimer.

Client Signature: _____

Client Name (Print): _____ **Date:** _____

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Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) establishes patient rights and protections associated with the use of protected health information. HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient 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 providers. Providers and healthcare agencies are required to provide patients a notification of their privacy rights as it relates to their health care records.

This Patient Notification of Privacy Rights informs you of your rights. Please carefully read this Patient Notification. It is important that you know and understand the patient protections HIPAA affords you as a patient.

In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship; therefore, we will do all we can do to protect the privacy of your mental health records. Please contact your counselor if you have questions regarding matters discussed in this Patient Notification. Please print, sign, and date this form below to acknowledge that you have familiarized yourself with the Confidentiality/HIPAA practices of LIFE FOCUS, INC.

I,_____, have been provided a copy of the LIFE FOCUS, INC. Patient Notification of Privacy Rights. My signature below indicates that I had the opportunity to review this document prior to signing it.

Client Signature: _____ **Date:**_____