Emily Shupert, LPC, MABC

{Simplified} Life Solutions

Counseling Intake Forms

Greetings!

Below is some basic information about my practice such as fees and hours of operation. In addition, I've included intake information that will be helpful to know in assisting you in your counseling journey. I look forward assisting you during your counseling journey soon!

Emily Shupert, LPC, MABC

General Information:

Hours and Dates: See Online Scheduling Program for Openings and Specifics

Mondays: 10am-7pm
Tuesdays: 10am-7pm
Wed: 10am-7pm
Thursdays: 10am-6pm
Fridays: 9am-noon

Fees: 1 Hour……..$120
(The 'hour' is 55 min and includes 5 minutes for handling administrative details such as scheduling the next appointment, etc.)

Qualifications

I have received both undergraduate and graduate degrees in Counseling Psychology. I am a Licensed Professional Counselor and am completing a PhD in Counseling. For over 7 years, I have worked in clinical child life therapy and counseling private practices in Dallas, Chicago, and Atlanta. Prior work experience may be shown upon request.

Nature of Counseling

You have the right to choose alternatives and to participate in designing your treatment plan. The therapeutic relationship, which we establish, will be characterized by respect and cooperation. Through therapeutic techniques and methods, I will offer you ways in which you can reach your counseling goals and objectives. My services will be practiced in a professional manner that is consistent with the Georgia State Board of Examiners of Professional Counselors qualifications for ethical standards. You are entitled to an explanation of your condition and the treatment that will be provided as well as the probable duration and adverse risk involved. Please know that it is impossible to guarantee any specific results regarding your counseling goals for the counseling process, however, together we can work to achieve the best possible results for you.

Confidentiality

Confidentiality is the cornerstone for building our couching relationship. I understand that you will not confide in me if you believe that the information discussed will be revealed d to others. Therefore, I assure you that you can trust me as your counselor. As a mental health professional, I follow The Health Insurance Portability and Accountability Act (HIPAA), which has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA applies to all health care providers and requires me to provide patients a notification of my privacy rights as it relates to client health care records.

As your counselor, I will keep confidential anything that you say to me with the following exceptions: when authorized by you to discuss with others involved in your health care; when ordered by the Court of Law to disclose information, for supervision purposed or for back up coverage when I am out of town, ill, or otherwise not available. I am bound by legal and ethical parameters to breech confidentiality when someone is in imminently suicidal, homicidal or if a minor is being abused physically or sexually.

Counseling Fees/Insurance

My counseling fee for a standard 55 minutes session is $120. While I do not accept insurance, I do offer sliding scale fees for those experiencing financial hardship. You may choose to submit insurance claims on your own for out of network mental health coverage. Please let me know if you would like a receipt at the end of each month to submit to your insurance provider for your personal reimbursement. Please remember to keep your payments current and if you experience a financial challenge that impacts your ability to pay, let me know so that I can work with you. In the event of lack of payments received for over 2 sessions, no further sessions will be made until the balance is paid in full. Please make payments to: Emily Shupert.

Telephone and Email Contact

The purpose of email, telephone, or other electronic correspondence is to assist in our communication regarding scheduling, appointment information, homework assignments, and information regarding payment status. This type of communication is not a way to communicate therapeutic information regarding your counseling care and treatment as these matters are saved for your counseling session time. While I will take reasonable, precautions to protect your confidential information, as with any electronic communication, there is no way to completely secure communication.

While I strive to be available when needed, please note that I am not "on call" for emergencies. If you have an emergency, you will need to contact a hospital emergency room, 911, or the police.

Public Contact

In the event that you see me outside of the counseling office, my policy is to not acknowledge you until or unless you respond first. If you would like to acknowledge me or not, I will not be offended as it is completely dependent upon your level of comfort and desire for discretion.

Cancellation Policy

In the event that you need to cancel your scheduled session time, please give at least 24 hours in advance warning. If you neglect to give 24-hour advance notice, the regular fee rate will be charged except in the event of a true emergency.

Supervision

I will be consulting with my supervisor on occasion with Tim Bouman, LPC. Please let me know if you have a previous relationship with him.

I have read the above information and voluntarily request counseling services from Emily Shupert, MABC, LPC, and I agree with the terms and conditions.

Signature of Client _____ Date _____

As undersigned, I am acknowledging that I am seeking services for my child (named above) to engage in a professional relationship with Emily Shupert, MABC, LPC, and agree to the terms and conditions.

Signature of Parent/Guardian _____ Date _____

{Simplified} Life Solutions
Payment Information

Payments are required at the date of services. You may pay through cash, check or credit cards. If you wish to pay by credit card, please complete the following:

Credit card: MasterCard □ VISA □
Number: _____
Expiration Month _____ Year _____
Address where bill is sent:
Street _____ City _____
State _____ Zip _____
Name as it appears on the card: _____

{Simplified} does not accept insurance as payment for services, although we will make every effort to provide the information necessary for you to file for reimbursement. You are responsible for payment at the time services are rendered.

By signing below you are indicating that you have read and agree to the above contract and that you also give authorization to {Simplified} to release any information necessary for you to secure insurance reimbursement for fees you have paid to restoration:

_____ _____
Client's Signature Date

_____ _____
Counselor's Signature Date

{Simplified} Life Solutions
Patient Notification of Privacy Rights

THIS FORM DESCRIBES THE CONFIDENTIALITY OF YOUR MEDICAL RECORDS, HOW THE INFORMATION IS USED, YOUR RIGHTS, AND HOW YOU MAY OBTAIN THIS INFORMATION. (EFFECTIVE 4-14-03)

LEGAL DUTIES
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

USE OF INFORMATION
Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

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 or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

DUTY TO WARN AND PROTECT
When a client discloses intentions or a plan to harm another person or persons, the health care 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.

PUBLIC SAFETY
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

ABUSE
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 health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

IN THE EVENT OF A CLIENT'S DEATH
In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

PROFESSIONAL MISCONDUCT
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions
When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Your Rights
You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $1 per page, plus postage. You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing. You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing. Your have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file. You have the right to know what information in your record has been provided to whom. Request this in writing. If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

Complaints
If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Georgia Board of Counseling. If you file a complaint we will not retaliate in any way.

{Simplified} Life Solutions
Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protection surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and the storage and access to health care records ("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 patients 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. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords to 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 we make every effort to do all we 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 for further clarification.

By law, {Simplified} Atlanta counselor, coaches, and other professionals is required to secure your signature indicating you have received a copy of the Patient Notification or Privacy Rights document.

{Simplified} Atlanta, INC/ Emily Shupert, MA, LPC
HIPAA Compliant Officer

Patient Name (print) _____

I have received a copy of the Patient 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 that I have the right to review this document and that I may at any time, now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy.

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Date

{Simplified} Life Solutions
Waiver of Confidentiality

I,_____, whose address is_____do hereby consent and authorize:

{Simplified} Life Solutions counselor and/or coaches

To release information specified below to/To receive information specified below from:

I authorize the release of this information ____ verbally or____ in writing, by my signature below:

___Personal identifying information
___Education and school-related information
___Employment and work-related information
___Psycho-social history and related information
___Drug and alcohol information (for the sole purpose of assessment and/or treatment)
___Treatment recommendations
___Other_____

The authorized information is released only to the person named above. The information will be released with a warning that any further use of this information is a violation of confidentiality. I understand that this consent is revocable except to the extent that the action has been taken in reliance thereon and that this consent will remain in force until _____.

Dated this _____day of _____, 200__.

_____
Signature of Client

_____ _____
Signature of Parent or Guardian Printed Name of Parent or Guardian

_____
Witness

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Unless the records of your program are also subject to Federal Law, federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose

PRE-COUNSELING PROFILE

The following comprehensive form, which will become a part of your confidential file, will help me focus most clearly on your areas of concern. Please answer each question fully. If a question does not apply to you, simply write "N/A". Unless otherwise requested, **please bring these forms with you to our first session.**

Date:_____

1. **Name:** _____
2. **Address:** _____ **Phone:** _____

   City/State:_____ **Zip:** _____
3. **Age:** _____
4. **Occupation:** _____ **Business Phone:** _____
5. **Marital Status: Single** _____ **Married** _____ **Remarried** _____ **Divorced** _____ **Widowed**_____
6. **Referred by:** _____
   (Name) (Address)
7. **Education: Circle last year completed**

   Grade School - 1 2 3 4 5 6 7 8 High School - 1 2 3 4

   College - 1 2 3 4 5 6 + Other Training: _____
8. **Note your physical health: Very Good** _____ **Good** _____ **Average** _____ **Declining** _____
9. **List significant past illnesses, injuries, handicaps** _____
10. **Have you used drugs for other than medical purposes?** _____
    If so, what?_____

Religious:

11. **Your denominational preference:** _____ **Spouses preference** _____
12. **What is your relationship with God?** _____
13. **Explain any recent changes in your religious life** _____
    _____
    _____

II. CLINICAL

1. **Have you ever had psychotherapy or counseling?**

2. **If so, when and from whom?**

3. **What did you like the most and what did you like the least about your prior counseling experiences?**

4. **List any prescribed medication you are presently taking:**

3. **What is the main problem as you see it?**

4. **What have you already done about it?**

5. **What are your goals in coming for counseling?**

II. CLINICAL (cont.)

7. Problem Areas

In the following list, place a check mark next to each item, which identifies an area of concern to you. Place <u>two</u> checks by those items, which are most important. (You may add written comments after areas checked).

_____ **Anger/Temper**

_____ **Children**

_____ **Depression**

_____ **Education**

_____ **Family problems**

_____ **Fatigue**

_____ **Fearfulness**

_____ **Financial problems**

_____ **Headaches**

_____ **Inferiority feelings**

_____ **Loneliness**

_____ **Insomnia**

_____ **Marital problems**

_____ **Nightmares**

_____ **Physical problems**

_____ **Pornography**

_____ **Problems with social relationships**

_____ **Religious/spiritual concerns**

_____ **Sexual concerns**

_____ **Thoughts of suicide**

_____ **Trouble making decisions**

_____ **Unable to relax**

_____ **Unhappy most of the time**

_____ **Use of alcohol/drugs**

_____ **Work**

_____ **Worry**

_____**Other** _____
(specify)

8. PLEASE COMPLETE THE FOLLOWING

1. **The most important thing to me is** _____
2. **I worry about** _____
3. **What I do best is** _____
4. **I have sometimes felt guilty about** _____
5. **I have been criticized for** _____
6. **What makes me angry is** _____
7. **My biggest mistakes were** _____
8. **My job** _____
9. **What makes me nervous is** _____
10. **My personality would be better if** _____
11. **I often felt that my mother** _____
12. **My temper** _____
13. **My childhood** _____
14. **Prayer is** _____
15. **My biggest disappointment** _____
16. **To me, sex is** _____
17. **I would be better liked if** _____
18. **I often felt that my father** _____
19. **God to me is** _____
20. **My child/children (brothers and sisters)** _____
21. **Women are** _____
22. **What hurts me most is** _____
23. **My biggest problem in life is** _____
24. **Men are** _____
25. **I am afraid** _____
26. **I wish** _____

III. GENERAL FAMILY HISTORY

1. **Date and place of birth**

   _____

2. **Approximately how many times did you family move when you were young?** _____

3. **Parents**

   If separated or divorced, how old were you at the time? _____

   Father deceased? _____ **How old were you at the time?** _____

   Step-father deceased? _____ **How old were you at the time?** _____

   Mother deceased? _____ **How old were you at the time?** _____

   Step-mother deceased? _____ **How old were you at the time?** _____

   Father remarried when you were age _____ **You lived with whom?** _____

   Mother remarried when you were age _____ **You lived with whom?** _____

   Until age 18 tell how long you lived with Mother _____ **Father** _____

   Step-mother _____ **Step-father** _____ **Other** _____

   How did the step-parent relate to you? (kindly, poorly, affectionately, little discipline, etc.)

   _____

   _____

   Natural father's occupation _____

   Natural mother's occupation _____

   Step father's occupation _____

   Step mother's occupation _____

   How many times was your father married? _____ **Your mother?** _____

   Rate your parent's marriage: Miserable _____ **Unhappy** _____ **Average** _____
   Happy _____ **Very Happy** _____

   Their marriage lasted _____ **years**

4. **Siblings**

List your brothers and sisters (indicating stepbrothers and sisters) from oldest to youngest including yourself. **Please include any miscarriages or abortions that you know of**

Name	**Sex**	**Age**	**Marital Status**	**Job**	**Describe each person**

Describe the relationship you have with your brothers and sisters

a. **Past**

b. **Present**

IV. MARITAL INFORMATION (When Applicable)

1. **Name of spouse: _____ Age: _____ Religion: _____**
2. **Occupation: _____ Business Phone: _____**
3. **Is your spouse willing to come for counseling? Yes _____ No _____ Maybe _____**
4. **Have either of you ever filed for divorce? Yes _____ If Yes, When _____ No _____**
5. **Date of this marriage _____ Ages when married: You _____ Spouse _____**
6. **Give brief information about any previous marriages _____**
   _____
   _____
   _____

   Divorce _____ Death _____
7. **Areas in your marriage that need improvement: _____**

VI. INFORMATION ABOUT CHILDREN

Please list names of your children from oldest to youngest. State if any of these children are from a previous marriage or adopted. Also, in birth order please include any miscarriages or abortions.

Name	Sex	Age	Marital Status	Job Description

***Please state if there are specific concerns about any child