Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

Minor Child Full Legal Name: _____

Parent/Guardian Full Legal Name: _____

Relationship to Child: _____

Health Insurance Portability and Accountability Act (HIPAA)

I have had an opportunity to read the Health Insurance Portability and Accountability Act Notices of Privacy Practices located in our office lobby and on our website at:
https://perimetertherapy.com/wp-content/uploads/2021/04/HIPAA_Form.pdf

Parent/Guardian Signature: _____

Information, Authorization, and Consent to Treatment

Welcome to *Perimeter Therapy Associates*. We are very pleased that you selected our facility for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist or group leader, policies regarding confidentiality and emergencies, and several other details regarding your treatment here at *Perimeter Therapy Associates*. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist or group leader is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Theoretical Views & Client Participation

It is our belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist/group leader at any point.

For therapy to be most successful, it is important for you to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without the therapists here at *Perimeter Therapy Associates***.** We also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit.

Confidentiality & Records

Your communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our business office. It is filed under your first name and last initial to protect your confidentiality to the fullest extent. Additionally, your therapist will always keep everything you say to him or her completely confidential, with the following exceptions:

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

(1) you direct your therapist to tell someone else and you sign a "Release of Information" form; (2) your therapist determines that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential. As a client of Perimeter Therapy, you are agreeing not to involve your clinician in any legal matters.

Please note that in couple's counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

If you engage in Group Therapy at Perimeter Therapy your private information will be protected by your Group Therapist exactly as in Individual Therapy. However, unlike for Individual Therapy, Perimeter Therapy cannot guarantee that other members of the group will keep information revealed in group sessions confidential. By signing this consent, you acknowledge that Perimeter Therapy cannot be held liable for any breaches of confidentiality caused by other group participants. It may also occur that some members of the group have the group therapist also as their individual therapist, while others do not. By signing this consent, you acknowledge this difference and agree to participate under these conditions. It is also possible that particular members may leave and/or join the group at various times. Signing this consent gives your agreement to participate under these changing conditions.

Structure and Cost of Sessions

Your Masters level therapist agrees to provide psychotherapy for the fee of $140.00 per 60-minute session, $175.00 per 75-minute session, and/or $210.00 per 90-minute therapy session, $60.00 per 90-minute group session, unless otherwise negotiated by you or your insurance company. Your PhD level therapist agrees to provide psychotherapy for the fee of $165.00 per 60 min session, $190.00 per 75-minute session, and/or $225.00 per 90-minute therapy session, unless otherwise negotiated by you or your insurance company. Doing psychotherapy by telephone is not ideal and needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed at $2.00 per minute. The fee for each session will be due at the conclusion of the session. ***Any balances owed over 30 days without a payment plan set up will be turned over to a HIPPA compliant collections agency. Payment plans established with a late payment of 30 days or more, and/or a payment less than the payment plan agreement will be turned over to a HIPPA compliant collections agency.***

Parent/Guardian Signature: _____

Cash, personal checks, Visa, and MasterCard are acceptable for payment, and we will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $25 fee for any returned checks. Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. We will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. We will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify your therapist at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions and you are responsible for the session amount as specified above in the ***Structure and Cost of Sessions*** section.

In Case of an Emergency

Perimeter Therapy Associates is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Georgia Crisis & Access Line (GCAL) 1-800-715-4225
- Call 911
- Go to your nearest emergency room.
- Call Peachford Hospital at 770.455.3200
- Call Ridgeview Institute at 770.434.4567

Professional Relationship

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, your relationship with your therapist must be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature. Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their client(s) secret. As much as your therapist would like to, for your confidentiality he or she will not address you in public unless you speak to him or her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection. Statement Regarding Ethics,

Client Welfare & Safety

Perimeter Therapy Associates assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association and/or the American Counseling Association and/or the National Association of Social Workers. If at any time you feel that your therapist is not performing in an

Please initial that you have read this page (Parent/Guardian Initials): _____

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

ethical or professional manner, we ask that you please let him or her know immediately. If the two of you are unable to resolve your concern, please contact Heather Youngblood, LCSW (e.g., Agency Director) at 678-666-4717.
Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility, nonetheless.
Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Therapy Termination
If you choose to end therapy without discussing your decision with your therapist and simply fail to attend a scheduled session, your therapist will call you one time to follow up with you. If your therapist does not hear from you, your therapy is considered terminated at that time and a termination/closing statement will be placed in your file.
We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask your therapist.
Regarding adolescents, parents have the right to examine all records of their minor child; however, in your child's best interest, Perimeter Therapy Associates asks that you waive that right, and allow your clinician to maintain therapeutic confidentiality. Your clinician will always inform parents if they have reason to believe that a child is in danger in any way. If your child is 18 or older, clinicians will need his/her explicit consent in order to communicate with you, regardless of who is paying for the sessions. Parent/Guardian Initials: _____

Informed Consent for TeleMental Health Services

The following information is provided to clients who are seeking TeleMental health therapy. This document covers your rights, risks and benefits associated with receiving services, my policies, and your authorization. Please read this document carefully, note any questions you would like to discuss, and sign.

TeleMental Health Defined:

TeleMental health means the remote delivering of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery.

Limitations of TeleMental Health Therapy Services:

While TeleMental health offers several advantages such as convenience and flexibility. It is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see various details such as facial expressions. Or, if audio quality is lacking, I might not hear differences in your tone of voice that I could easily pick up if you were in my office.

Please initial that you have read this page (Parent/Guardian Initials): _____

1455 Lincoln Parkway Suite 240 678-666-4717
Atlanta, GA 30346 info@perimetertherapy.com

Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. As the therapist, I will take every precaution to insure a technologically secure and environmentally private psychotherapy sessions. As the client, you are responsible for finding a private quiet location where the sessions may be conducted. Consider using a "do not disturb" sign/note on the door. The virtual sessions must be conducted on a WiFi connection for the best connection and to minimize disruption.

In Case of Technology Failure:

I understand that during a TeleMental health session we could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call the therapist back at:
Please make sure you have a phone with you, and you have that phone number. We may also reschedule if there are problems with connectivity.

Structure and Cost of Sessions:

I offer face-to-face psychotherapy when appropriate and available. However, based on your ability to make in-person sessions and my availability, I may provide virtual psychotherapy if your treatment needs determine that TeleMental health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental health, or both. We will discuss what is best for you. Please remember that your insurance company may or may not cover therapy via phone or video. We are both responsible for understanding your mental health benefits. Please contact your insurance provider to verify coverage via TeleMental health.
The structure and cost of TeleMental health sessions are exactly the same as face-to-face sessions described in the general "Authorization & Consent to Treatment" and "Insurance Agreement" forms. Texting and emails (other than just setting up appointments) are billed at my hourly rate for the time I spend reading and responding. I require a credit card ahead of time for TeleMental health therapy for ease of billing. Please make sure you have signed the Credit Card Information Form, which was sent to you separately and indicates that I may charge your card without you being physically present. Your credit card will be charged at the conclusion of each TeleMental health interaction.

Email:

Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.
I also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to me via email because I may not see it in a timely matter. Instead, please see below under "Emergency Management Plan." Please use the TheraPortal to send secure communications and share documents.

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:
Please refer to our Social Media Policy. Clinicians at Perimeter Therapy Associates are not able to "friend" clients on Facebook or other social media sites or connect on LinkedIn as this could compromise the confidentiality of clients. Our clinicians also do not Tweet with clients. Please refrain from contacting me using social media messaging systems such as Facebook Messenger or Twitter. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

Electronic Transfer of PHI and Credit Card Transactions:
I utilize KASA for billing and as the company that processes your credit card information. I may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will appear on your credit card bill. You can send secure documents through the TheraPortal including payment information. I will use this as the primary method of communication regarding payment and other personal health information related sharing.

Cancellation Policy:
In the event that you are unable to keep either a face-to-face appointment or a TeleMental health appointment, you must notify me at least 24-hours in advance. **If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.**

Parent/Guardian Initials:

Emergency Management Plan:
In the event of an emergency, it is imperative you are aware of resources in your area. As a precaution, I have identified two (2) nearby emergency hospitals below. In addition, you will need to provide information for an emergency contact person. These all must be completed to participate in TeleMental health services.

1. Hospital Name and Location: Peachford Hospital 2151 Peachford Rd, Dunwoody, GA. 30338
   Hospital Telephone Number: 770.425.3200
2. Hospital Name and Location: Ridgeview Institute 3995 S Cobb Dr SE, Smyrna, GA 30080
   Hospital Telephone Number: 770.434.4567

Emergency Contact Person: _____

Relationship to Client: _____

Emergency Contact Person Telephone Number: _____

Parent/Guardian Signature: _____

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

You may alternatively follow this plan:

- Call the Georgia Crisis and Access Line (GCAL) at 1-800-715-4225
- Call 911
- Go to your nearest emergency room.
- Call Peachford Hospital at 770.455.3200
- Call Ridgeview Institute at 770.434.4567

I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Parent/Guardian Signature: _____

Consent to Treatment:
I voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Perimeter Therapy Associates to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Perimeter Therapy Associates at any time.
By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.
Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I've done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm.
Please use technology with discretion. Only communicate limited information such as appointment request, cancellations, or estimated time of arrival.

I consent to the use of the following forms of communication via technology:

___ Texting

___ Email

___ Fax

___ Document Sharing via TheraPortal, DocuSign, and/or email

___ Recommendations to Websites or Apps

Parent/Guardian Signature:

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

Credit Card Information

Unless paid by cash or check, I authorize Perimeter Therapy Associates to charge my credit/debit card for professional services, if incurred:

1) Missed appointments (no cancellation or cancellation less than 24 hours before the appointment) is a session charge (not a copay charge but a full session charge as insurance companies do not reimburse for missed sessions. Please reference the **Structure and Cost of Services** section above for billable rates)
2) Telephone consultations and telephone call (calls between therapist and client and therapist and others) exceeding 10 minutes, charged in 10-minute intervals based on normal hourly rate.
3) Documentation preparation charged at normal hourly rate.
4) Other requests requiring a significant investment of time to execute charged in 10-minute intervals based on normal hourly rate.
5) Returned check: full amount, plus charge of 25.00 per instance.
6) Any unpaid balance will be charged to this card 30 days after your most recent date of service.
7) Any balances owed over 30 days without a payment plan set up will be turned over to a HIPPA compliant collections agency. Payment plans established with a late payment of 30 days or more, and/or a payment less than the payment plan agreement will be turned over to a HIPPA compliant collections agency.

Minor Child Full Name: _____

Parent/Guardian/Payor Full Name: _____

Master Card: ___ Visa: ___ American Express: ___

Provide your full 16-digit credit card number here: _____

Expiration Date: _____

3-digit CVN identification number on back of card: _____

Parent/Guardian Signature: _____

Credit card information will be saved in our computer system which is encrypted for privacy.

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

INSURANCE AGREEMENT (Please read carefully)

As a service to you, Perimeter Therapy Associates will bill your insurance company if we are an in- network provider with them. Due to the rising costs of healthcare, however, insurance benefits have become increasingly more complex. Although we are extremely thorough and spend a great deal of time ascertaining your benefits at the forefront as well as filing your claims accurately, we still cannot guarantee that your insurance company will follow through with their original statement of benefits. In some cases, insurance companies have been known to change benefits in the middle of a policy year without notification to Perimeter Therapy Associates as the provider. In other cases, session visit limits, deductibles, or maximum allowables may vary from those originally quoted to us, thereby altering, or altogether preventing claims from paying in accordance with the benefits we as the provider have on file.

Additionally, it is our ethical obligation to be sure that you are aware of the following information regarding insurance companies. Most insurance companies require mental health practitioners to disclose certain information about their clients in order to receive benefits. First and foremost, they always require a diagnosis. Frequently, they require additional information to justify ongoing treatment. This information includes physical health concerns you may have, psychosocial stressors (such as problems in relationships, work, etc.), and your general level of functioning. Insurance companies often require treatment plans, and they occasionally require copies of the therapist's notes. It is our policy to protect your confidentiality by providing only the information that is absolutely necessary. All of this information will become part of the insurance company's records and is usually stored in a computer database.

If your insurance policy changes, terminates, or defaults to a secondary insurance, it is your responsibility to notify your therapist of this change. **(If you do not inform your therapist and our billing office of insurance changes, you will be responsible for all session charges that are accrued as a result of claim denials.)**

Perimeter Therapy Associates has a 24-hour cancellation policy. If you cancel an appointment with your therapist with less than 24-hours notice, you will be financially responsible for the session.

Since insurance companies do not pay for missed sessions, you will need to pay for the full amount of your session rather than just your co-pay. Please reference the Structure and Cost of Services section above. Again, it is your responsibility to make sure that your therapist always has the most up to date information on file regarding your insurance company as well as your most up to date contact information.

Primary Insurance Company (PIC): _____

PIC Phone Number: _____

PIC Address to Mail Claims: _____

Insured ID #: _____

Group#: _____

Parent/Guardian Employer Name: _____

Parent/Guardian Employer Phone Number: _____

Parent/Guardian Employer Address: _____

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

Parent/Guardian Full Legal Name: _____

Parent/Guardian Date of Birth: _____

Spouse/Guardian Full Legal Name: _____

Spouse/Guardian Date of Birth: _____

Spouse/Guardian Employer: _____

Spouse/Guardian Employer Phone Number: _____

Spouse/Guardian Employer Address: _____

Primary Doctor (of minor child): _____

Primary Doctor (of minor child) Phone Number: _____

Some insurance plans require that your therapist maintain contact with primary care physicians. Information to be released to your Primary Care Physician includes your diagnosis, any medication prescribed, the name of your therapist and the date of your initial visit.

Your insurance copay is expected at the time of your appointment unless previous arrangements have been made with your therapist.

I have read the above policies, and I accept this Insurance Agreement.

Parent/Guardian Signature: _____

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

Social Media Policy

This document provides an overview of the Social Media Policy at Perimeter Therapy Associates. Please read and sign showing that you understand the way that clinicians at Perimeter Therapy Associates respond to various interactions that may occur between client and clinician on the internet.

Emails, cell phones, computers and faxes are not guaranteed to be 100% private. Although all clinicians at Perimeter Therapy Associates are required to have password protections on their computers and cell phones, it is important to realize that computers, email, and cell phone communication can be accessed by unauthorized persons and therefore can compromise the privacy and confidentiality of such communication. Please limit emails and texts to changes in appointment times, scheduling of appointments or other brief exchanges. If you choose to communicate confidential or private information via text or email, Perimeter Therapy Associates will assume that you have made an informed decision and will view it as your agreement to take the risk that this communication may not be 100% confidential. If you choose to email content related to your therapy sessions, please note that email is not completely secure or confidential. If email communication outside of sessions requires more than 5 minutes to read and respond to, you may be charged for professional services rendered in 10-minute increments. Please indicate in your email if you intend to pay for these services or if you would like your clinician to save the email for review during your session.

Clinicians at Perimeter Therapy Associates are not able to "friend" clients on Facebook or other social media sites or connect on LinkedIn as this could compromise the confidentiality of clients. Our clinicians also do not Tweet with clients. In public situations, clients have control over their own description of the nature of their acquaintance with their therapist. For example, if you see your therapist at church or school and you choose to ignore your therapist, your therapist will follow your lead and do the same. If you introduce your therapist to your friends, your therapist will agree with your description of how you know them. Thank you for taking your time to review these policies. If you have any questions or concerns, please bring them to the attention of your therapist. ***By initialing below, you are indicating that you have read this document, understand your rights, and accept the responsibility stated.***

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

Survey Consent Form

Perimeter Therapy Associates occasionally conducts online surveys to learn from our clients and gain insight and information about our practice from our clients' perspective. The information from these surveys is used for internal purposes to improve our services and offerings and will not be shared with any third parties.
The surveys are solicited via email and will use standard online tools to collect the survey responses. While these tools utilize industry standard privacy and security measures, they may not be explicitly HIPAA compliant. By choosing to respond to any requested survey information, you acknowledge and accept that you are making an informed decision to provide survey responses using email and/or online survey tools.

Check this box if you do NOT wish to receive survey requests:

Client Information

Client Full Legal Name (minor child): _____

Child's Date of birth: _____ Parent/Guardian Social Security #: _____

Parent/Legal Guardian Full Legal Name: _____

Home street address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Parent/Guardian Work Phone: _____

Parent/Guardian Cell Phone: _____

Parent/Guardian Email: _____

Calls will be discreet, but please indicate any restrictions:

_____

Biological parents are: ___ married ___ divorced ___ separated ___ widowed

If divorced, which parent holds the medical tiebreaker for the child? _____

(parent with medical tiebreaker/custody must be the one completing these documents)

Parent/Guardian Signature: _____

Divorce settlement agreement must be faxed, uploaded to patient portal, and brought to initial session.

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

Referred by: _____

May I have your permission to thank this person for the referral? Yes ___ No ___

If referred by another clinician, would you like for us to communicate with one another? Yes ___ No ___

If yes, a Release of Information (ROI) from will need to be completed. Your therapist can send you an ROI form or you may download one from our website, complete, and return to your therapist.

Person(s) to notify in case of any emergency:

Name: _____

Phone: _____

Relationship: _____

I will only contact this person if I believe it is a life-or-death emergency. Please provide your signature to indicate that I may do so:

Parent/Guardian Signature: _____

Please briefly describe your child's presenting concern(s):

What are your/your child's goals for therapy?

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?

Please explain any significant medical problems, symptoms, or illnesses:

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

**The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing. **

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses:

Child's Current Medications:

Name of Medication	*Dosage*	*Purpose*	*Name of Prescribing Doctor*

Does your child smoke or use tobacco? _____

If yes, how much per day? _____

Does your child consume caffeine? _____

If yes, how much per day? _____

Does your child drink alcohol? _____

If yes, how much per day/week/month/year? _____

Does your child use any non-prescription drugs? _____

If YES, what kinds and how often? _____

Previous medical hospitalizations (Approximate dates and reasons):

Previous psychiatric hospitalizations (Approximate dates and reasons):

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (Please list approximate dates and reasons):

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

Height: _____

Weight (if applicable): _____

Age: _____

Sexual Identity: _____

Gender Orientation: _____

Preferred pronouns: _____

FAMILY:

How would you describe your child's relationship with his or her mother?

How would you describe your child's relationship with his or her father?

Are the child's parents still married or did they divorce?
If they divorced, how old was the child when they separated or divorced, and how do you think this impacted him or her?

Please describe your child's relationship with his or her grandparents:

How many sisters does your child have?

Ages?

How many brothers does your child have?

Ages?

How would you describe your child's relationship with his or her siblings?

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

Social Support, Self-Care, and Education (please rate scales of 1-10 with 1 being poor and 10 being excellent)

Child's current level of satisfaction with friends and social support (1-10):

How would you describe your child's relationships with his/her peers?

Please briefly describe any history of abuse, neglect, and/or trauma:

Please briefly describe your child's self-care and coping skills:

What are your child's diet, weight, and exercise/activity patterns?

Please briefly describe your child's school performance and experience:

What are your child's hobbies, talents, and strengths?

What grade is your child in? _____

Child's favorite subject? _____

Least favorite subject? _____

Does your child have an Individualized Education Plan (IEP) or 504 Plan?

Does your child have any legal problems or court involvement?

Is there a mandate for treatment through the court system or the Division of Family and Children Services (DFCS)?

Is there an active DFCS case the child and/or the parents/guardians are involved in? ___ Yes ___ No
If yes, please explain:

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

PLEASE PLACE AN "X" BY ALL THAT APPLY PAST AND/OR NOW:

DIFFICULTY WITH	NOW	PAST	DIFFICULTY WITH	NOW	PAST	DIFFICULTY WITH	NOW	PAST
Anxiety			Tantrums			Nausea		
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in the Throat		
Headaches			Issues Re: Divorce			Sweating		
Loss of Memory			Sexually Acting Out			Heart Problems		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Separation Anxiety			Hurting Self			Fidget Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Waiting His/Her Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Head Injury			Sleeping Alone			Chills or Hot Flashes		

Which symptom above is your ***primary*** concern?

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disabilities		"Nervous Breakdown"	

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

Any additional information you would like to include:

Please date and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship and your child's relationship with your therapist/group leader, and you are authorizing the therapist/group leader to begin treatment with your child. You will receive an email copy of this paperwork for your records.

Date: _____

Child's Full Legal Name: _____

Parent/Guardian Full Legal Name: _____

Parent/Guardian Signature: _____

The signature of the Therapist below indicates that she or he has answered any questions you have regarding this information.

Therapist Name (Please Print): _____

Therapist's Signature: _____

Date: _____

Please initial that you have read this page (Parent/Guardian Initials): _____

Perimeter Therapy Associates

Individual, Couple, and Family Psychotherapy

1455 Lincoln Parkway Suite 240
Atlanta, GA 30346

678-666-4717
info@perimetertherapy.com

CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document.
The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below.

I, _____ (Parent/Guardian), hereby authorize _____ (Therapist - print) and the following party or parties to discuss the mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnosis regarding my child:

(1) _____

(2) _____

(3) _____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my medical and/or mental health information without limitations.

____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows: _____

Additionally, the above-named parties, therapist & person(s) or entity (entities) designated under (1) or (2), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality. Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above-named therapist at the address above to be effective.

Full Legal Name Child: _____

Full Legal Name of Parent/Guardian: _____

Parent/Guardian Client Signature: _____

Date: _____

Please initial that you have read this page (Parent/Guardian Initials): _____