CLIENT INFORMATION PACKET 2019

Shala Nicely, LPC
2993 Sandy Plains Road, Suite 125, Box 4
Marietta, GA 30066

Today's Date _____

Client's Name _____Date of Birth _____Age_____

Parent/Guardian's Name (if applicable) _____ Relationship _____

Home Address _____ City _____ Zip Code _____

May I send information to this address? ❑Yes ❑ No

If No, please provide an address where information can be mailed: _____

_____

Home Phone # _____ May I contact you at this number? ❑ Yes ❑ No ❑ Disguised

Cell Phone #_____ May I contact you at this number? ❑ Yes ❑ No ❑ Disguised

Work Phone # _____ May I contact you at this number? ❑ Yes ❑ No ❑ Disguised

If there are any further restrictions when calling you, please list them here _____

_____

Education Level Completed _____ Occupation _____

Person to notify in case of emergency _____ Phone _____

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_____

Referred by _____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

_____

How many sessions do you anticipate to address these concerns?

1-5 6-10 11-20 20+ I don't know

MEDICAL HISTORY

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

_____

_____

_____

_____

_____

Current Medications Date Started For What Condition? Dosage/Frequency Side Effects

Please include over-the –counter medications and vitamins

_____

_____

_____

_____

_____

Past Medications Date(s) For What Condition? Dosage/Frequency Side Effects

_____

_____

_____

_____

Do you smoke or use tobacco? ❑ Yes ❑ No If yes, how much per day? _____

Do you consume caffeine? ❑ Yes ❑ No If yes, how much per day? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much per day/week/month? _____

Do you use any illicit drugs? ❑ Yes ❑ No If yes, which? _____

Do you exercise? ❑ Yes ❑ No If yes, how often? _____

PSYCHIATRIC HISTORY

Have you ever talked with a mental health professional before today? ❑ Yes ❑ No

If yes: Date(s) Professional Seen Reason Type of Treatment

_____

_____

_____

Would you like me to contact any of your previous providers? ❑ Yes ❑ No

If yes, please provide their contact information _____

_____

_____

RELIGION/SPIRITUALITY

Is religion or spirituality important to you? ❑ Yes ❑ No Please describe: _____ _____

_____

_____

FAMILY INFORMATION

Are you currently in a relationship? ❑ Yes ❑ No If yes: ❑ Married ❑ Partnered

How long in current relationship? _____ Any previous significant relationships? ❑ Yes ❑ No

Please list all the people that live in your household and your relationship to them:

Name _____ Relationship _____ Age ____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age ____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age ____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age ____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age ____

Occupation _____ Education Completed _____

Please list any family members or others who do not live in your house, but who are important to you:

Name _____Relationship _____ Age ____ Where they live _____

Occupation _____ Education Completed _____

Name _____Relationship _____ Age ____ Where they live _____

Occupation _____ Education Completed _____

Name _____Relationship _____ Age ____ Where they live _____

Occupation _____ Education Completed _____

Name _____Relationship _____ Age ____ Where they live _____

Occupation _____ Education Completed _____

Has a family member (parents, siblings, grandparents, aunts/uncles, etc.) ever suffered from the following:

❑ OCD Who? _____

❑ Body Dysmorphic Disorder Who?_____

❑ Hair Pulling or Skin-Picking Disorder Who? _____

❑ Depression Who? _____

❑ Anxiety Who? _____

❑ Hoarding Disorder Who?_____

❑ Other Who/What? _____

LEGAL ISSUES

Have the concerns you have today resulted in any legal issues? ❑ Yes ❑ No

If yes, please describe briefly: _____

_____

Are you currently involved in any lawsuits, custody battles, or other legal battles? ❑ Yes ❑ No

Is therapy part of any court mandated requirement that you are required to complete? ❑ Yes ❑ No

BEHAVIOR CHECKLIST

Please mark if you have had difficulty with any of the following currently or in the past:

Mental Health Symptoms

Anxiety	☐ current	☐ past	Time of first onset _____
Depression	☐ current	☐ past	Time of first onset _____
Mood Changes	☐ current	☐ past	Time of first onset _____
Anger/Temper	☐ current	☐ past	Time of first onset _____
Panic	☐ current	☐ past	Time of first onset _____
Fears	☐ current	☐ past	Time of first onset _____
Irritability	☐ current	☐ past	Time of first onset _____
Concentration	☐ current	☐ past	Time of first onset _____
Loss of Memory	☐ current	☐ past	Time of first onset _____
Excessive Worry	☐ current	☐ past	Time of first onset _____
Feeling Manic	☐ current	☐ past	Time of first onset _____
Trusting Others	☐ current	☐ past	Time of first onset _____
Drugs	☐ current	☐ past	Time of first onset _____
Alcohol	☐ current	☐ past	Time of first onset _____
Frequent Vomiting	☐ current	☐ past	Time of first onset _____
Eating Problems	☐ current	☐ past	Time of first onset _____
Severe Weight Gain	☐ current	☐ past	Time of first onset _____
Severe Weight Loss	☐ current	☐ past	Time of first onset _____
Sleeping Too Much	☐ current	☐ past	Time of first onset _____
Sleeping Too Little	☐ current	☐ past	Time of first onset _____
Nightmares	☐ current	☐ past	Time of first onset _____
Head Injury	☐ current	☐ past	Time of first onset _____
Speaking w/o Thinking	☐ current	☐ past	Time of first onset _____
Completing Tasks	☐ current	☐ past	Time of first onset _____
Waiting your turn	☐ current	☐ past	Time of first onset _____
Paying Attention	☐ current	☐ past	Time of first onset _____
Easily Distracted	☐ current	☐ past	Time of first onset _____
Hyperactivity	☐ current	☐ past	Time of first onset _____
Making Careless Mistakes	☐ current	☐ past	Time of first onset _____
Fidgeting	☐ current	☐ past	Time of first onset _____

Relationships

With people in general	☐ current	☐ past	Time of first onset _____
Parents	☐ current	☐ past	Time of first onset _____
Current relationship	☐ current	☐ past	Time of first onset _____
Friends	☐ current	☐ past	Time of first onset _____
Coworkers	☐ current	☐ past	Time of first onset _____
Employer	☐ current	☐ past	Time of first onset _____
Finances	☐ current	☐ past	Time of first onset _____
Legal Problems	☐ current	☐ past	Time of first onset _____
Sexual Problems	☐ current	☐ past	Time of first onset _____
History of Child Abuse	☐ current	☐ past	Time of first onset _____
History of Sexual Abuse	☐ current	☐ past	Time of first onset _____
Domestic Violence	☐ current	☐ past	Time of first onset _____
Homicidal Thoughts	☐ current	☐ past	Time of first onset _____
Suicidal Thoughts	☐ current	☐ past	Time of first onset _____

Physical Symptoms

Increased Stress	☐ current	☐ past	Time of first onset _____
Fainting	☐ current	☐ past	Time of first onset _____
Dizziness	☐ current	☐ past	Time of first onset _____
Diarrhea	☐ current	☐ past	Time of first onset _____
Headaches	☐ current	☐ past	Time of first onset _____
Shortness of Breath	☐ current	☐ past	Time of first onset _____
Chest Pain	☐ current	☐ past	Time of first onset _____
Lump in Throat	☐ current	☐ past	Time of first onset _____
Sweating	☐ current	☐ past	Time of first onset _____
Heart Palpitations	☐ current	☐ past	Time of first onset _____
Muscle Tension	☐ current	☐ past	Time of first onset _____
Pain in Joints	☐ current	☐ past	Time of first onset _____
Allergies	☐ current	☐ past	Time of first onset _____
Chills	☐ current	☐ past	Time of first onset _____
Hot Flashes	☐ current	☐ past	Time of first onset _____

Any additional information that you would like to include: _____

_____

_____

_____

INFORMED CONSENT AND AUTHORIZATION

Shala Nicely, LPC
2993 Sandy Plains Road, Suite 125, Box 4, Marietta, GA 30066

The following contains important information about the professional services provided by Shala Nicely, LPC. This document is designed to inform you about what you can expect from me, and if we choose to enter into a therapeutic relationship, please know that it is a collaborative experience and I welcome any questions, comments, or suggestions at any time. By you signing this document we enter into an agreement that allows me, Shala Nicely, LPC, to provide therapeutic services to you.

Background Information

I received a Master of Science in Clinical Mental Health Counseling from Mercer University, and I am a Licensed Professional Counselor in the state of Georgia (LPC008785). I have experience working with adults, adolescents, and children with OCD and related disorders, anxiety disorders, and depression, and I have specialized training in treating clients with these issues using cognitive behavioral therapy (CBT), including exposure and response prevention (ERP) therapy. I am the co-author with Jon Hershfield, MFT of *Everyday Mindfulness for OCD: Tips, Tricks & Skills for Living Joyfully*, and the author of *Is Fred in the Refrigerator? Taming OCD and Reclaiming My Life*. I also blog for *Psychology Today*, offering an inside perspective on life with OCD and the lessons of uncertainty. I am the co-founder and past president of OCD Georgia, the Georgia affiliate of the International OCD Foundation (IOCDF), and I have served on the national conference planning committee for the IOCDF. I was also the keynote speaker for the 2013 IOCDF national conference. For more detailed information on my training and continuing education, please see the About Shala section of my website. My previous education includes a BS in Business Administration from the University of Illinois and an MBA from Emory University. I provide outpatient mental health services through my own company, Nicely Done, LLC.

Theoretical Views and Client Participation

I believe that a therapeutic relationship is based on a collaborative partnership between my clients and me, and that it is my job as a therapist to use research-based therapy approaches to help you address the issues that brought you to counseling. I believe that people have many of the resources they need to reclaim their lives from OCD and related disorders and anxiety disorders already within them, and that clients can learn more about themselves and these resources and develop skills to best use them during the therapeutic process.

Services Provided

During your first session, I will speak with you about the reasons that you scheduled your first appointment. If you are seeking therapy for a minor, I require that I meet with the parent(s)/guardian(s) alone for the first session. During this time a decision will be made between client and therapist as to whether or not we are a good fit for treatment or if an outside referral will be made to someone with more expertise in your area of need. Each therapy session typically lasts 45-50 minutes. The duration of the therapeutic process varies for each client. Some clients may feel resolution to their concerns in just a few sessions while others may take years to complete their process. Please note that when working with adolescents and children, the therapeutic process typically takes longer and is slower. Young people need to feel comfortable with the therapist with whom they are working and processing significant issues require high levels of trust and safety.

If at any time you wish to stop receiving services from me, I ask that you schedule one final session in order for us to have appropriate closure and to address any remaining needs that you may have.

Working with Adolescents and Children

I will update you on your child's progress before and after each session, and you may attend a number of sessions with your child as well. It is important that your child feel that my office is a place where they can trust me enough to share the sensitive things that may be underlying the presenting problem. Due to the importance of trust between client and therapist, when the client is a minor I will offer parents general information about the therapeutic process and overall themes, but not all specific details about what information is exchanged during each session. However, if at any time I feel like your adolescent is engaging in dangerous behavior, I will immediately inform you of the situation or have your child do so as part of the therapeutic process.

_____ I have read & understand this page (please initial)

Risks

Given the work required for personal growth and change to occur, therapy may involve some risks. During cognitive behavioral therapy, you may discuss difficult aspects of life or choose to confront uncomfortable thoughts, emotions, or situations that may lead to uncomfortable feelings or strong reactions as part of the therapeutic process. Making and adapting to changes in your life may have a profound impact on you and your relationships as well as challenge long held assumptions or behaviors. Reasonable efforts will be made to discuss the potential impact, positive and negative, that may result from the changes you make in your life as a result of therapy. Please ask questions if you have any concerns. There are no guarantees for successful therapy due to the overall complexity of the process and the multiple variables brought into it by each individual.

Confidentiality, Communication, & Records

The information you share with me in both written (i.e. intake paperwork) and verbal format is part of your Protected Health Information (PHI) and is considered confidential. A detailed description of PHI is included with this intake packet. Some of your PHI will be kept in a file stored in a locked cabinet in my locked office and some of your PHI will be stored electronically with TherapyNotes, who has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format.

Both text messaging and emailing are not secure means of communication and may compromise your confidentiality, and therefore, I do not communicate with clients via either email or texting. You can sign a form to elect to have TherapyNotes send you an automated email reminder of your appointment, and please note that you will not be able to reply to the email address that will be sending the reminders.

I will not release your PHI to anyone, including your family and insurance company if you are a legal adult, without *written* consent. If you are a minor, it is the legal right of your parents to have access to the information that we discuss in our sessions. I will discuss with each minor client and their parent/guardian the expectations of exchange of information between parties for their particular situation. It may be imperative to my therapeutic relationship with an adolescent not to reveal the information disclosed to me in session to their parents/guardians. It is important that all parties involved in the therapeutic process are clear on our communication expectations. It is important that you understand the legal limitations to confidentiality which include, but are not limited to:

1) When individuals express intent to harm themselves or others, the therapist may be required to break confidentiality to assure the health and safety of all concerned.
2) Therapists are mandated by law to report to the appropriate state authorities information documenting child and/or elder abuse or neglect.
3) When a judge orders that information be disclosed. I cannot guarantee that an appeal will be upheld, but I will do everything in my power not to disclose your confidential information.
4) When Homeland Security requests information, according to the Patriot Act.

Any files that have no activity for a period of one (1) month will be closed.

Protecting Your Privacy

To protect your privacy, if we happen to see each other outside of session, I will not initiate contact (e.g. say hello, acknowledge that we know each other) unless you choose to do so first.

Social Media

I am restricted by the Code of Ethics by which I abide from entering into dual relationships with clients except in very limited circumstances where these relationships would be beneficial to you. "Dual relationship" means any relationship outside of our therapeutic relationship. To abide by this code, I am not able to accept any requests to friend, like, or otherwise connect via the web or social media sites such as Facebook, LinkedIn, and Twitter.

Waive right to subpoena

In order to protect you and the information you and/or your child(ren) provide to me during our sessions I ask each client to waive their right to call me as a witness to court for any reason. The communication that you/your child(ren) provide during session is considered privileged by O.C.G.A. § 24-5-501 and covers "communications between a …

_____ I have read & understand this page (please initial)

licensed professional counselor and patient." If you anticipate the need for a therapist's involvement in court activity I will be happy to refer you to someone who is more suited to meet your needs. If for any reason I am required to participate in court proceedings my fee of $185 per 50 minutes will be applied from door to door. In addition, I reserve the right to charge for court preparation including case review, report preparation, and legal and ethical review at $185 per 50 minutes.

Clinical Diagnosis for Insurance Purposes

Many clients decide to seek reimbursement for services through their insurance company. While I do not accept any forms of insurance directly, I am willing to provide you a "superbill" with information that will help you seek reimbursement from your insurance company. Please be advised that most insurance companies require a diagnosis in order for reimbursement to occur. Any diagnosis submitted to an insurance company will become a part of you/your child's permanent medical record.

Please make sure your insurance company understands I am out of network. If any insurance company thinks I am in network, they may start sending correspondence and/or check to me, which will delay your reimbursement.

Fees

Clients seen by Shala Nicely, LPC agree to pay $185.00 per 45-50 minute session to Nicely Done, LLC. The fee for travel time to and from therapy appointments that are not held in my office is $100/hour. Any services beyond the standard 45-50 minute session, such as phone consultation exceeding 15 minutes, excessive paperwork, or court appearances/preparation, may incur additional fees as listed above. Shala Nicely, LPC reserves the right to announce fee increases, and if I do so, will endeavor to provide one month's notice before the new fees go into effect. I will be happy to provide you with a receipt for payment. Receipts of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $35 fee for returned checks. Should you miss a payment, for whatever reason, therapy sessions may be postponed until the full payment is rendered. If your credit card is declined repeatedly or if you are unable to pay on the date of service, an additional charge of $10 may be added to your invoice. You are responsible for the full payment at the time service is provided.

Insurance companies have many rules and requirements specific to certain plans. If you choose to file with your insurance company for reimbursement, it is your responsibility to understand their policies and requirements for reimbursement. I will be glad to provide you with a statement for your insurance company provided you sign a written release of information giving me permission to do so.

Cancellations

You are expected to attend all scheduled sessions with your therapist. I understand that "life happens" and that unexpected interruptions occur particularly with adolescents, but I do expect you to make therapy a priority. If you need to cancel your appointment please call **NO LATER THAN 24 HOURS PRIOR** to your scheduled appointment. If you cancel your appointment without 24-hour notification, a $75 cancellation fee will be charged to your card for the first occurrence. Subsequent late cancellations will incur the full charge of the scheduled session. No shows (missing an appointment without notice) will be charged the full scheduled session fee.

I require all clients to provide a credit card number to keep on file in the case of missed or cancelled appointments. This information is kept in a confidential file that is locked at all times. Please note that insurance companies do not reimburse for missed appointments.

Emergencies

Shala Nicely, LPC does not provide emergency services. I do not carry a pager and I am not available at all times. If this does not feel like it will be sufficient support for you, please inform me and we can discuss additional resources or transfer your case to a therapist or clinic that has 24 hour availability. Generally, I will return phone calls within 24-48 hours during the week. Should I be out of town, I will make every effort to alert you of my absences. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

1) Call 911
2) Go to the emergency room of your choice
3) Call Emory University Hospital at Wesley Woods at 404-728-6222 (continued on next page…)

_____ I have read & understand this page (please initial)

4) Call Ridgeview Institute at (770) 434-4567 or Peachford Hospital at (770) 454-2302
5) Call the Georgia Crisis & Access Line at 1-800-715-4225 or the National Suicide Prevention Lifeline at 1-800-273-TALK (8255)

Ethical Considerations

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of my profession. If at any time you feel that I am not performing in an ethical or professional manner, please let me know immediately, and if I'm unable to resolve your concern, I will provide you with information to contact the American Counseling Association and/or the National Board of Certified Counselors, which govern my profession.

In order to maintain ethical standards I find it helpful to occasionally consult with other professionals. In these consultations I do not reveal the identity of my client(s). The consultant is also bound to keep any information about a case confidential by the ethical standards of their own professional association. I do not consult with therapists who are not bound by such ethical standards.

Authorization and Consent to Treatment

By signing below you agree that you have read (or have had read to you) all of the above sections of the informed consent form and that you understand the risks and benefits associated with the therapeutic process. You understand that you can ask questions about the process at any time. You agree to the policies stated above, including agreeing to pay the disclosed fee for services rendered and to provide 24 hours notice to cancel your appointment.

If Applicable:

_____ _____

Signature (Client/Parent/Guardian) Date Minor's Name

_____

Signature (Client/Parent/Guardian) Date

_____

Shala Nicely, LPC Date

Initial here:

_____ I have read & understand the "Working with Adolescents" section.
_____ I have read & agree to the "Waive Right to Subpoena" section.
_____ I have read & understand the "Cancellations" section.

CREDIT CARD POLICY

Shala Nicely, LPC
2993 Sandy Plains Road, Suite 125, Box 4
Marietta, GA 30066

I am hereby entering into a contract for Shala Nicely's professional time and services when I set an appointment. I understand that by entering this contract for Shala Nicely's professional time I am specifically contracting for her services to prepare for my session in advance. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and consultations with other professionals as agreed in writing by me to assist with my treatment. I understand that Shala Nicely's cancellation policy requires 24 hours advance notice in order to be released from the contract for Shala Nicely's time and services of preparation for my session. I agree that if I fail to cancel my appointment before the 24-hour minimum time period prior to my session I will be charged a cancellation fee of $75 or the entire session fee (see cancellation policy) for the missed session and the services provided in preparation for the appointment. I hereby authorize Nicely Done, LLC to charge the following card if I indeed fail to observe this cancellation policy and I understand I am paying for preparation services rendered and time contracted for when I set the appointment.

Visa / Mastercard / Amex / Discover (please circle)
Credit card number_____
Expiration date_____
CVV code (3 or 4 digits on the back of the card)_____
Zip code to which billing statement is mailed_____
Name on credit card _____

I have read and understand the above credit card policy for services provided by Shala Nicely, LPC. Please have all consenting adults sign below.

_____ _____
Signature Date

_____ _____
Signature Date

HIPAA PRIVACY RULE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I, _____, understand and have been provided a copy of the Client Notification of Privacy Rights Document (on Shala Nicely's website, shalanicely.com) 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 I have the right to review this document before signing this acknowledgment form.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. **NOTE: USES AND DISCLOSURES MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.**

_____ _____

Client Signature or Parent if Minor Date

COMMUNICATIONS

I wish to be contacted in the following manner (check all that apply):

Cell Phone Number_____
___OK to leave message with detailed information
___Leave message with name & call back number only
___ Do not leave messages on cell

Written Communication
___ OK to mail to my home address
___ OK to fax to this number_____

Home Phone Number_____
___OK to leave message with detailed information
___Leave message with name & call back number only
___ Do not call me at home.

Work Phone Number _____
___OK to leave message with detailed information
___Leave message with name & call back number only
___ Do not call me at work.

Email Appointment Reminders
I consent to Shala Nicely, LPC using TherapyNotes to send me email reminders before my group and/or individual appointments. I understand that Shala does not communicate with clients via email other than sending appointment reminders, and I will not be able to reply to the email address that will be sending the reminders.

Email address (please print clearly): _____

_____ _____

Client/Parent/Guardian Signature Date