



PURPOSELY DESIGNED LIFE  
PSYCHOTHERAPY & CONSULTING

**NEW CLIENT INTAKE FORM**

**Client Information:**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Which phone number would you prefer to receive voice mail messages on? \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer or School Name: \_\_\_\_\_

Employer Address, City, State, Zip: \_\_\_\_\_

Employed: ( ) Full time ( ) Part time Student: ( ) Full time ( ) Part time

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

**Party Responsible for Payment: (if different from above please fill out entirely)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Employer or School Name: \_\_\_\_\_

Employer Address, City, State, Zip: \_\_\_\_\_

**Insurance:**

Name, birth date and social security number of insured:

\_\_\_\_\_  
\_\_\_\_\_

Insurance Company: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Group and other insurance ID numbers: \_\_\_\_\_

**Medical Information:**

Health Problems: \_\_\_\_\_

Physician Name and Phone Number: \_\_\_\_\_

Current Medications and Dosage: \_\_\_\_\_

**Please read and sign the following agreement. Do not sign it unless it is clear to you.**

I have reviewed the Psychotherapist-Client Services Agreement and the Notice of Privacy Practices. I understand my and Purposely Designed Life, LLC’s rights and responsibilities, and agree to be bound by those documents. I give Purposely Designed Life, LLC permission to bill my insurance company for services. I understand that I am responsible for paying my fee, regardless of whether my insurance covers it.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**I authorize Purposely Designed Life, LLC to charge my credit card (Visa, Discover or Master Card) for any balances overdue by 90 days.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Credit Card Number

\_\_\_\_\_  
Exp. Date

.....  
**Office Use Only below this line**

Diagnosis Code:

Session Fee:

Pre-certification and verification of benefits:

Deductible:

% paid by insurance:

Maximum fee:

Yearly Maximum:

Lifetime maximum:

Marital covered?

How to bill?

Billing address \_\_\_\_\_

If client has BCBS insurance: Date of current Illness/injury: \_\_\_\_\_

Same/Similar Illness-first date: \_\_\_\_\_

Billing Instructions:

- File with insurance company       Request insurance company to reimburse client directly
- Client will handle insurance if any       Send monthly bill to client       Do not bill client



PURPOSELY DESIGNED LIFE  
PSYCHOTHERAPY & CONSULTING

## PSYCHOTHERAPIST – CLIENT SERVICES AGREEMENT

Welcome to Purposely Designed Life, LLC; Fostering wholeness, wellness, and completeness as you live out and in your purpose. We are glad you have chosen us as your place for personal growth and recovery. This document contains important information about our professional services and business practices. **Please read it carefully** and feel free to discuss any questions you have with your therapist.

### **Philosophy of Care at Purposely Designed Life, LLC**

We believe that treatment of the whole person is necessary for growth and development. This means that psychological, physical, spiritual, relational and fiscal issues may be addressed in therapy. Therapy is most effective when the Client is active in the therapeutic process. This means you will be expected to work on things discussed in therapy both during session and at home.

Psychotherapy has both benefits and risks. Risks sometimes include painful feelings such as sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy also often involves discussing unpleasant aspects of anxiety and distress as well as better relationships, greater self-esteem and resolution of specific problems.

### **The First Few Sessions**

In the first few sessions your therapist will want to evaluate your treatment needs and learn more about you. During this time you and your therapist will work together to create treatment goals and an initial plan for treatment. Most importantly, this is your time to evaluate your comfort level and confidence in your choice of therapist. Your therapist will also be evaluating if they are a good choice of therapist for you and your specific needs and goals at this time. If for some reason you do not feel as though you are with the right therapist for you, please tell your therapist, as we would like to assist you in finding the right match.

### **Contacting Therapists and Emergencies**

Calls are answered by a confidential voice mail system and each therapist has their own direct extension. Therapists check their voice mail each business day unless they are unavailable for an extended period of time. If your therapist is away, they are responsible for asking another therapist to be available to you, and their contact information will be included in your therapist's outgoing voice-mail message. Therapists will make every effort to return calls within 48 hours. It is best to leave some contact times when you are available to be reached. **If your therapist is unavailable and you are experiencing an emergency please call the nearest hospital and ask for the psychiatrist on call or dial 911; you may also contact the Georgia Crisis and Access Line (GCAL) at 1-800-715-4225**

### **Professional Records**

The laws and standards of the mental health profession require therapists to keep Protected Health Information (PHI) about you in your clinical record. It is important to understand that pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and updated in 2013, your therapist may keep PHI about you in two sets of professional records. One set is your clinical chart, which may be accessed by third parties (such as insurance companies) with your written authorization. Some therapists keep a second record, referred to as Psychotherapy Notes. These notes are only for use by your therapist and may include contents of therapeutic conversations, analysis of those conversations and how they impact treatment. These notes are kept separate from your clinical record and cannot be released to insurance companies without your authorization. Insurance companies cannot penalize you if you refuse to authorize disclosure of psychotherapy notes. You may examine and/or receive a copy of your clinical and psychotherapy notes if you request this in writing. Because these records can be misinterpreted it is recommended that you review them in the presence of your therapist or have them

forwarded and reviewed with another mental health provider. Your therapist may charge a copying fee if you request a copy of these records.

### **Records of Minors**

Clients under 12 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Parents of children between 12 and 18 cannot examine their child's records unless the child consents and the therapist finds no compelling reason to deny the access. Parents can request information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Since parental involvement, if usually crucial to successful treatment, it is recommended that Clients between 12 and 18 years of age and their parents enter into an agreement that allows parents access to treatment information.

For children under the age of 18, all paperwork should be co-signed by both parents. Signature of both parents is required in all cases of separation and all divorce situations involving any type of joint custody. Although not required by law, it is preferred to have both parents agree to treatment even in cases of sole custody with no stipulation regarding medical treatment.

### **Cost**

The fee for a 60 minute session is \$175. For individuals having challenges to afford co-payments or cost of sessions please speak with your therapist about your situation since it is likely that we could work out an alternative financial arrangement. It is also important to know that fees may be charged for lengthy telephone conversations over 20 minutes and time spent providing other services on your behalf. This may include extensive report writing, preparation and photocopying records or treatment summaries, consulting with other professionals with your consent, and attendance at staffing. If you become involved in legal proceedings that require your therapist's participation you will be expected to pay for all of their professional time including preparation and transportation costs, even if they are called to testify by another party. Please discuss this with your therapist so that you clearly understand what services you will be charged for. In addition, therapists reserve the right to limit phone calls or other uses of their time to what they consider clinically appropriate. They will discuss these limits with you should they become an issue.

### **Use of Insurance**

Insurance is a complex issue. **We ask our Clients to call their insurance company to discover what mental health/chemical dependency coverage is available.** Mental health coverage is usually different than physical health coverage. Please ask your insurance company if you need pre-certification, what your co-pay is given our hourly rate, and how many sessions you are allowed in what period of time as well as if there is a co-insurance payment. We reserve the right to call your insurance company and verify coverage and benefits. We provide the courtesy of billing your primary insurance company and ask for you to make your co-payment at the time of service. We also ask that you assume the responsibility of tracking the usage of allotted sessions. In this regard you should take the initiative to discuss with your therapist (1) the number of sessions remaining before further approval is needed, and (2) when no further sessions are available under your policy.

**Ultimately you are responsible for full payment of fees that your insurance company does not agree to cover.** Therefore it is important to you to fully understand your coverage benefits regarding mental health and/or chemical dependency. You will be responsible for discussing with your health insurance company any disputes regarding coverage. If you are disputing a claim for lack of payment with your insurance company Purpoely Designed Life, LLC, may request that you pay your balance with us and agree to be reimbursed by the insurance company at a later date if the matter is eventually resolved.

### **Other Billing Issues**

Purposely Designed Life, LLC, has a 24-hour cancellation policy for all sessions including group therapy. Insurance companies do not cover missed appointments. You will be billed \$70 if you fail to cancel with at least 24 hours notice.

We ask that you provide a credit card number for us to keep on file to cover balances that are more than 30-days overdue. We will notify you in the event that we bill your card.

Purposely Designed Life, LLC, does use a collections agency and may do so if an account is 90-days past due and compliance with a suitable payment plan has not occurred. If it is necessary to take legal action to collect fees then attorney's fees and costs will be included in the claim. Rather than enter an adversarial situation we encourage you to speak directly to your therapist should financial issues arise which make timely reimbursement impossible.

**Confidentiality**

**Georgia law protects the privacy of all communications between a Client and a mental health provider. In most situations, if you are 18 years of age or older, your therapist can only release information about your treatment to others if you sign a written authorization form and meet certain legal requirements imposed by HIPAA and/or Georgia law.**

**Therapists are mandated reporters and as such we have the legal obligation of notifying appropriate authorities in the following situations. Please note that these situations are handled with the utmost care to protect those at risk for harm and with respect to the Client's confidentiality.**

- If your therapist believes that you present a clear, imminent risk of serious physical or mental injury or death to yourself.
- If you have made a specific threat of violence against another or if your therapist believes you present a clear, imminent risk of serious physical harm to another.
- If your therapist has reasonable cause to believe that a child under 18 known to your therapist in her professional capacity may be abused or neglected by a parent, caretaker, or other person responsible for the child's welfare.
- If your therapist has reason to believe that an adult over 59 years old, or under 60 years old and who is disabled, has been abused, neglected, or financially exploited in the preceding 12 months.
- In accordance with Georgia Firearm Concealed Carry Act of 2013 if you are determined to be a clear and present danger to yourself or others, developmentally disabled or intellectually disabled your therapist may be responsible for reporting your mental health information to the Georgia Department of Human Services.

\_\_\_\_\_  
Signature of Client (12 years and older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian (children up to 18 years)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian (children up to 18 years)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date



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**PAYMENT CONSENT FORM**

Client Name \_\_\_\_\_  
Last First Middle

I agree to be responsible for full payment of my bill due to Purposely Designed Life, LLC. I understand that Purposely Designed Life, LLC prefers to receive payment in the form of credit card or cash. I also understand that Purposely Designed Life, LLC may charge my credit card for any unpaid or overdue balances. I agree to provide a current, valid credit card for this purpose. I understand that charges may appear on my credit card statement as Professional Charges, Square, or Purposely Designed Life, LLC. I authorize Purposely Designed Life, LLC to charge my credit/debit card for professional services as follows:

Please Initial

\_\_\_\_\_ This visit only, for the amount of \$ \_\_\_\_\_.

\_\_\_\_\_ All visits in the next 12 months, beginning \_\_\_\_/\_\_\_\_/\_\_\_\_ not to exceed \$ \_\_\_\_\_ total.

\_\_\_\_\_ Recurring charges, date(s) of service \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_, not to exceed \$ \_\_\_\_\_.  
\_\_\_\_\_ monthly, \_\_\_\_\_ semimonthly, \_\_\_\_\_ weekly, \_\_\_\_\_ per visit.

\_\_\_\_\_ **To charge my card for the balance of fees not paid by my insurance company (required) within 90 days.**

Type of Card:

\_\_\_\_\_ Visa \_\_\_\_\_ MasterCard \_\_\_\_\_ Discover \_\_\_\_\_ Medical Flex/Savings

Name as it appears on Card \_\_\_\_\_

Card Holder's Address \_\_\_\_\_

Credit Card Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_, CVV Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ A 3-digit number on the back of credit card

Card Holder Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**AUTHORIZATION FORM**

This form, when completed and signed by you, authorizes employees of Purposely Designed Life, LLC to release and obtain protected information to/from the person(s) or agency or agencies you designate. I authorize Purposely Designed Life, and administrative staff to release and/or obtain the following:

- |  |  |
|--|--|
| <input type="checkbox"/> verbal exchange | <input type="checkbox"/> clinical chart (excludes psychotherapy notes) |
| <input type="checkbox"/> billing records | <input type="checkbox"/> other   |

This information should only be released to or received from (names and addresses):

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

I am requesting Purposely Designed Life, LLC to release and to obtain this information for the following reasons:

- |  |   |
|--|---|
| <input type="checkbox"/> At the request of the client              | <input type="checkbox"/> For consistency of treatment |
| <input type="checkbox"/> For treatment planning and implementation | <input type="checkbox"/> For Payment Purposes         |

This authorization shall remain in effect until \_\_\_\_\_ (usually one year from today's date).

**If no calendar date is stated, information may be released only on the day the authorization form is received by Purposely Designed Life, LLC.**

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to my therapist at Purposely Designed Life, LLC. However, revocation will not be effective to the extent that my therapist has already released information based on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand I have the right to inspect the disclosed mental health information. I understand that Illinois Law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such a re-disclosure. I further understand that if information is released to a party in another state, re-disclosure of information may be allowable according to their state law. I also understand that once Purposely Designed Life, LLC releases information, it has no responsibility or control over how that information is stored or utilized.

\_\_\_\_\_  
Signature of Client (12 years and older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian (children up to 18 years)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian (children up to 18 years)

\_\_\_\_\_  
Date



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**SIGNATURE PAGE**

Please initial the following statements to indicate that you agree. If an item is not applicable please write N/A.

- \_\_\_\_\_ 1) I have completed and signed the **New Client Intake Form**.
- \_\_\_\_\_ 2) I have read and signed the **Psychotherapist-Client Services Agreement**.
- \_\_\_\_\_ 3) I have completed and signed the **Payment Consent Form**.
- \_\_\_\_\_ 4) I have completed and signed the **Authorization Form**.
- \_\_\_\_\_ 1) I have received a copy of **Purposely Designed Life, LLC Notice of Privacy Practices**.
- \_\_\_\_\_ 4) I have provided my **insurance card** to be photocopied.
- \_\_\_\_\_ 5) I have provided my **credit card number** for coverage of overdue balances.
- \_\_\_\_\_ 7) I agree to hold confidential the identities and personal information of any other clients that I may see or interact with at Purposely Designed Life, LLC

**Your signature below indicates that you have received the Psychotherapist-Client Services Agreement and the Notice of Privacy Practices and that you agree to abide by its terms. These documents represent an agreement between you and your therapist. You may revoke this agreement in writing at any time. However, revoking either of these two agreements will result in termination of professional services provided to you by your therapist. Your signature below also indicates that you have initialed all the above statements which were applicable.**

Client \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian\* \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian\* \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

\*Parent signature is required for clients under age 18. Signature of both parents is usually required.