ROSWELL THERAPY GROUP, LLC

500 SUN VALLEY DRIVE, SUITE C-1
ROSWELL, GA 30076
(770) 640-9242
Fax: (770) 640-9287
Charlesastokes@yahoo.com
Charles A"Skeet" Stokes, P.C.

Welcome to the Roswell Therapy Group. While you're waiting, and in order to serve you better, please review the following, acknowledge your understanding and acceptance by your signature, and complete the attached COUNSELING PROFILE.

Counseling Guidelines

1. The usual counseling session hour is for 50 minutes duration, first sessions can run longer.

2. The normal counseling fee is ______ per hour. Should the session run past 60 minutes, you will be charged at a rate of ¼ hour for each additional 15 minute interval.

3. Payment is expected at the end of each session. Visa, Master Card, Check, or Cash

4. An appointment represents time set aside personally for you. Missed appointments are billed at the Usual Fee when they are not canceled by 9 a.m. the Previous Day, Monday appointments by 5p.m. the Previous Friday.
   If not made in person, Please leave a voice mail at 770-640-9242 AND send email to charlesastokes@yahoo.com.

5. Insurance assignment is not accepted and statements for your filing with insurance providers can be provided at your request with advance notice. Please check in advance with your provider for coverage of my services.

6. Fees are subject to change at any time.

Notice of Privacy Practices

All statements that are made are of a confidential nature, including all written information, and may not be disclosed without written consent.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This notice is a shorter version of the full, legally required NPP and you may have a copy of this to read and refer to it for more information. However, we can't cover all possible situations so please talk to our Privacy Officer (see the end of this notice) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities which are called, in the law, health care **operations.** After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it. For example:

(A) When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.

A counselor working with adults and children may be encouraged or required by law to disclose to the appropriate person, agency, or civil authority any harm that a person may attempt or desire to do to one's self or to others, or any reasonable suspicion of physical or sexual abuse being done or having been done to a minor child. This counselor reserves the right to make such reports.

B) To insure the highest quality of service and in the best interest of the client, your counselor reserves the right to consult with another professional regarding your treatment. This consultation will be held in strict professional confidence.

1. Some lawsuits and legal or court proceedings.

2 If a law enforcement official requires to do so.

3. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Note: By your signature on this from your are consenting to communication with you, your referral source, attending physicians, insurance providers, your spouse, and/or other family members via phone, email, fax, and written sources as necessary for your Therapist to conduct therapy with you. Your rights regarding your health information.

You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.

If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.

You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Have you been arrested? Yes___ No____ Please Explain?____________________________

____

Are currently involved in any litigation or Court Order? Please Explain _________________

____

Are You or your Spouse consider a divorce or has filed for a divorce? Yes: ____ No ______.

NOTE: If you and/or your spouse become a plaintiff and/or defendant with each other and/or a third party, You and/or your agent(s) agree NOT to Subpoena and/or Depose Charles A Stokes, Charles A Stokes PC, Skeet Stokes and/or Roswell Therapy Group LLC.

NOTE: From time to time, I Audio/Video Record Sessions to assistant in therapy, client feedback, my personal continuing education and may be shared with another professional with the understanding it is done so under professional consultation and with full professional confidentiality for all. These recordings are not part of your personal medical file and may be destroyed at anytime without your permission and will not be available form legal action or for any other reason other than stated.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer who is Charles A. "Skeet" Stokes, MS, LPC, LMFT. And can be reached by phone at 770-640-9242.

The effective date of this notice is April 14, 2003.

Also, you may have other rights which are granted to you by the laws of our state and these may be the same or different from the rights described above. I will be happy to discuss these situations with you now or as they arise.

By my signature, I acknowledge to my counselor that I have read, understood, and have agreed to the **Counseling Guidelines**, the **Notice of Privacy Practices**, the NOTE: Concerning Legal Actions, NOTE: Concerning Audio/Visual Recording, and that I accept and agree with the above stated conditions and limits of confidentiality. I acknowledge responsibility for all fees incurred and should collection of my account be necessary, I will be responsible for all cost of litigation including attorney's fees.

____ _______________

(Your Signature) (Date)

____ _______________

(Counselor's Signature) (Date)

(30/1/2017)

The Roswell Therapy Group Counseling Profile

Date ______________________________Counselor ____

NAME____________________________________SS____

Address____
Street City State Zip
HomePhone___________________WorkPhone__________________CellPhone___________________

Email_____________________________ Employer/Occupation__________________________

Birth date/Age _______________________ Male ____ Female ____

Current Marital Status: Mar. _____ Sep. _____ Div. ______Date of Marriage: ___________________

NAME OF SPOUSE _______________________________________ Birthdate/Age_____________

Employer and Occupation ____

Work Phone __________________Cell Phone______________ Email___________________________

CHILDREN'S names, sex, Birth date, ages and use * if by previous marriage

______________________________________ _______________________________________

____ ______________________________________

EMERGENCY CONTACT:
Name____

Address ____ Phone__________Email:_______________

REFERRED BY: ____ Phone__________
May we have permission to contact the person who referred you? Yes _____ No _____

EDUCATION: Circle the last year you completed.

Grade School 1 2 3 4 5 6 7 8 High School 1 2 3 4 College 1 2 3 4 5 6+

Other training
____

MEDICAL:
Describe any physical problems you have that require medication or physical care:

PHYSICIAN'S Name, address Phone____
____

Are you currently receiving medical treatment: _______ Yes ________ No

What medications are you currently taking:____

Have you used drugs for other than medical purposes: _______Yes ________No

If so, what? ___________________________________When_____________________________

What problems bring you here at this time?____
____
____

When did these problems begin?
____
____

Are alcohol and drugs involved? ____

PREVIOUS COUNSELING/THERAPY ______ Yes _______ No If yes, when? _______________
With whom?
_______________________________________Where?___________________________________
(Name)
____
(Address) (Phone)

Have you ever been hospitalized for emotional reasons or substance abuse? ______ Yes ______ No
(Explain)
____

____

Have you had past thoughts of suicide or suicide attempt? ______ Yes ______ No (Explain)
____
____

Do you presently feel suicidal? ______ Yes ______ No
(Explain)____
____

Comments:
____

____

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Fax 770-640-9287
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Charles A. "Skeet" Stokes, PC

Authorization to Debt Charge Card

I acknowledge responsibility for all fees incurred and should collection on my account be necessary, I will be responsible for all cost of litigation and collection including attorney's fees. As per the **Counseling Guidelines, Page 1 of 8,** missed appointments are billed at the full fee when they are not cancelled by 9 a.m., the Previous Day, and Monday Appointments not cancelled by 5p.m. the Previous Friday. In the event I/We should miss an appointment, I am authorizing Charles A. Stokes/Charles A. Stokes, P.C./ Roswell Therapy Group to charge my account below to cover this fee. This agreement applies to myself, my spouse, my children, parents, and/or others participating in therapy in conjunction with me and/or for whom I have agreed to cover the cost of therapy without my being involved in the sessions.

Card Holder Name: (Print)____

Card Number: ___ ___ ___ ___ -- ___ ___ ___ ___ -- ___ ___ ___ ___ -- ___ ___ ___ ___

CVV Security Code:____________

Expiration Date: ___ ___ / ___ ___ **Card Type: Visa**_______ **Master Card:** _______

Debit: ___________ **Credit:** _____________

Card Billing Address: ____

____

City: ____

State: ____________________ **Zip Code:** _________________

Person(s) whose cost of therapy I am authorizing debiting above card:

Name(s)____

____

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CVV Security Code:____________

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Debit: __________ **Credit:** ____________

Card Billing Address: ____

____

City: ____

State: ___________________ **Zip Code:** ________________

Person(s) whose cost of therapy I am authorizing debiting above card:

Name (s)____

____

Signature:____**Date:**_________________

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Consent to use and disclose your health information

This form is an agreement between you, ______________________________ and your counselor. When we use the word "you" below, it can mean you, your child, a relative, or other person his or her name here: Name: ____ .
When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy your Privacy Officer listed above.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

____ ________________
Signature of client or his or her personal representative Date

____ _________________________
Printed name of client or personal representative Relationship to the client

____
Signature of authorized representative of this office or practice. Date of NPP (04/14/2003)

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If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer who is Charles A. "Skeet" Stokes, MS, LPC, LMFT. And can be reached by phone at 770-640-9242.

The effective date of this notice is April 14, 2003.

Also, you may have other rights which are granted to you by the laws of our state and these may be the same or different from the rights described above. I will be happy to discuss these situations with you now or as they arise.

By my signature, I acknowledge to my counselor that I have read, understood, and have agreed to the **Counseling Guidelines**, the **Notice of Privacy Practices**, and that I accept the stated conditions and limits of confidentiality. I acknowledge responsibility for all fees incurred and should collection of my account be necessary, I will be responsible for all cost of litigation including attorney's fees.

____

(Your Signature) (Date)

____

(Counselor's Signature) (Date)

Your Copy of Page 3

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Consent to use and disclose your health information

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Name: ____ .
When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

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____ ________________
Signature of client or his or her personal representative Date

____ __________________________
Printed name of client or personal representative Relationship to the client

____
Signature of authorized representative of this office or practice. Date of NPP (04/14/2003)
(3/01/2017)

YOUR COPY of Page 8