

**Atlanta Center for Cognitive Therapy**  
**Intake Information**

(Guardians, fill out this form for children under 18 years old with the child's information. Write guardian's contact information.)

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Sex: M F

Address \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Soc. Sec. # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Phone(s): Home (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Circle One: S M D W Sep Sig. Other

Referred by \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Legal Guardian \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_

Spouse's Name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ State \_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_

Dependents: Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Nearest relative (not living with you in case of emergency) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Relation \_\_\_\_\_ Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Do you have Insurance Coverage for this visit? Yes or No

Who is Financially responsible for this bill? \_\_\_\_\_

(For clinician) Intake Date ____/____/____ Name of Therapist _____ Diagnosis _____
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**FINANCIAL POLICY**

1. Each therapist has his/her own fee schedule and will discuss this with you. The usual therapy session consists of 45-50 minutes. Time is also spent by the therapist charting notes following your visit and reviewing notes prior to subsequent visits.
2. The first appointment involves assessment and is usually an extended session. Your therapist will discuss type of evaluation and fees with you.
3. Except under extraordinary circumstances, payment is expected at the time of your appointment. If you need to make special arrangements for payment, please discuss this with your therapist.
4. If an appointment is not cancelled 24 hours ahead of the scheduled appointment time, the client will be charged the arranged fee for that appointment. Since insurance companies do not pay for missed appointments, you bear the full cost of “no shows” or late cancellations. You are asked to leave a message with your therapist’s voicemail or our answering service after hours and on weekends if you must cancel an appointment.
5. Returned checks shall be subject to service charges; and, balances older than 30 days shall be subject to interest charges of 1 to 1 ½ % per month.
6. We must emphasize that as mental health care providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you state on record that you do not have insurance or that you do not wish insurance to be filed, you are personally obligated to pay agreed upon fees to your therapist, even if you reveal you have insurance at a later date.

PERSONAL STATEMENT: I understand that I will be responsible for payment of fees for my treatment and that a receipt for insurance purposes will be provided if requested. Non-payment of fees billed may result in turning your account over to a collection agency. I further understand that a 24—hour cancellation notice must be given for any appointment that must be cancelled. Otherwise, I agree to pay in full the usual fee for the missed appointment.

\_\_\_\_\_  
Responsible Party

\_\_\_\_\_  
Date

D. Scott Greenaway, Ph.D.  
Name of Practitioner

\_\_\_\_\_  
Fee

Please Note: The confidentiality of the information that you share with your therapist is protected by state law and professional ethics. However, state law and professional ethics require that therapists ensure the safety of their clients and others when therapists have reason to believe their clients or others are in danger. The confidentiality of the relationship between therapist and client may be broken in such instances.



**Acknowledgment of Receipt of  
Notice of Privacy Practices related to HIPAA\***

I understand that a copy of the *Notice of Privacy Practices* is posted on Dr. Greenaway's website: psychologyatlanta.com. I may receive upon request a printed version of this document from Dr. Greenaway or at the business office of the Atlanta Center for Cognitive Therapy.

**Signature** (client/patient or representative): \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship/authority** (if signed by representative): \_\_\_\_\_

\*HIPAA: Health Insurance Portability and Accountability Act of 1996



**AUTHORIZATION FOR TREATMENT OF MINORS**  
(for clients/patients under 18 years old)

I authorize D. Scott Greenaway, Ph.D. to administer services and/or treatment to my child.

Child's Name \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Printed Name of parent or guardian

\_\_\_\_\_  
Date



### **Cancellation Policy**

We request at least 24 hours advance notice for all cancellations or rescheduling. ACCT reserves the right to bill you, personally, for missed appointments. If you do not give 24 hours advance notice.

For patients who come for weekly therapy, keeping the constituency of attendance is important for the therapy to be most beneficial. When you do need to cancel, it is recommended that you reschedule for another day during the same week.

The term “no-show” refers to a situation when a client does not call to cancel or reschedule and does not show up for an appointment. After 3 no-shows, ACCT reserves the right to make appropriate referrals to other providers and terminate your case at ACCT. ACCT also reserves the right to terminate a case after a client shows a consistent pattern of cancelled appointments.

### **Confidentiality Policy**

Things you and your child talk about in therapy/counseling are kept confidential, and your (or your child’s) records are kept in a double-locked, monitored facility.

In general, information regarding treatment at ACCT cannot be discussed with another individual unless you sign a Release-of-Information form for that individual or institution. Exceptions to this rule are as follows:

- 1.) The clinician may provide information regarding your treatment to your insurance company. Only enough information to ensure proper payment is allowed.
- 2.) If your provider believes that you are in imminent danger of hurting yourself or somebody else, your provider is legally mandated to break confidentiality in order to protect you or another person.
- 3.) If your provider believes that a child, handicapped individual, or an elderly person is in an abusive situation (physically, sexual, emotional, or neglect), the provider is legally mandated to break confidentiality to protect that person.
- 4.) If your provider is court-ordered to release information related to a particular trial, the provider is legally mandated to break confidentiality and release the requested records. This applies to an official order from the court and does not apply to requests made by lawyers.

### **When a Client Wants to Stop Therapy**

If you decide that you are ready to terminate services at ACCT, rather than simply not coming any more, please discuss this matter with your clinician, so that your case may be closed appropriately. For therapy cases, it is highly recommended that there be a “termination session,” where you and your therapist can discuss treatment progress or lack thereof, what has and hasn’t been helpful in the process, and your feelings regarding the closure of therapy. Many times, therapy clients will decide to temporarily stop therapy with the intention of returning at some point in the future. This is certainly appropriate and can also be discussed at the termination session.

If you have any questions about these policies, please speak with your clinician.