Robyn S. Gruber, MA, NCC, CPCS, LPC

3535 Roswell Road, Building 29, Marietta, GA 30062

robyn@RobynGruberLPC.com **678-665-8455** **www.RobynGruberLPC.com**

NAME _____ Date of Birth_____
Last First Middle

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

E-MAIL ADDRESS _____

You may communicate appointment information to me via ☐ text ☐ cell phone ☐ email ☐ home phone

Education _____ Occupation/Employer _____

In case of a life and death emergency, you have my permission to contact_____

Cell Number_____ Signature _____

What prompted you to seek treatment at this time? _____

_____

_____

_____

Have you received treatment for this same problem before? ☐ yes ☐ no If so, please describe.

_____

_____

Are you currently being treated by a psychiatrist, psychologist or counselor/therapist? ☐ yes ☐ no

_____
Name Dates Reason

Were you referred to me by a medical professional or therapist? ☐ yes ☐ no

Name and phone number of referring clinician _____

Do I have your permission to thank them for their referral? ☐ yes ☐ no

Do you want me to communicate with them about your treatment? ☐ yes ☐ no

How did you find me? ☐ Internet search ☐ Psychology Today ☐ Insurance Panel ☐ Friend/family

Please list any medical conditions you have_____

_____

Please list any medications you currently take, including dose, reason for use and prescribing physician.

_____

_____

_____

_____

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? _____

Has anyone ever told you that you drink too much? □ yes □ no If, yes, who? _____

Do you use non-prescription drugs? □ yes □ no If yes, what and how often?_____

_____

Have you ever been hospitalized? □ yes □ no If yes, please give approximate dates and reasons:

_____

_____

_____

Describe your current living situation. Do you live alone, with other, with family, etc.? _____

_____

Are you currently in a relationship? □ yes □ no If yes, describe the nature and length of the relationship.

_____

Have you previously been married or in a long-term relationship(s) that ended? □ yes □ no Describe.

_____

_____

_____

Please describe problems in any relationships you are having at this time._____

_____

_____

What changes do you want to see in yourself as a result of therapy? _____

_____

_____

Do you believe these changes are possible? □ yes □ no □ maybe □ not sure

Please check any symptoms you are currently experiencing and about how many days/week you experience these symptoms.

□ Increased appetite	1 2 3 4 5 6 7	□ Excessive worry	1 2 3 4 5 6 7
□ Decreased appetite	1 2 3 4 5 6 7	□ Anxiety	1 2 3 4 5 6 7
□ Unintentional weight gain	1 2 3 4 5 6 7	□ Fear	1 2 3 4 5 6 7
□ Unintentional weight loss	1 2 3 4 5 6 7	□ Hopelessness	1 2 3 4 5 6 7
□ Trouble concentrating	1 2 3 4 5 6 7	□ Panic	1 2 3 4 5 6 7
□ Difficulty sleeping	1 2 3 4 5 6 7	□ Intrusive thoughts	1 2 3 4 5 6 7
□ Falling asleep □ Staying asleep □ waking early			
□ Excessive sleep	1 2 3 4 5 6 7	□ Racing thoughts	1 2 3 4 5 6 7
□ Nightmares	1 2 3 4 5 6 7	□ Panic	1 2 3 4 5 6 7
□ Low motivation	1 2 3 4 5 6 7	□ Feeling overwhelmed	1 2 3 4 5 6 7
□ Isolation from others	1 2 3 4 5 6 7	□ Suicidal thoughts	1 2 3 4 5 6 7
		Have you ever attempted suicide? □ yes □ no	
□ Fatigue/low energy	1 2 3 4 5 6 7	If yes, when? _____	
□ Irritability	1 2 3 4 5 6 7	Were you hospitalized? □ yes □ no	
□ Low self-esteem	1 2 3 4 5 6 7	□ Thoughts of hurting anyone	1 2 3 4 5 6 7
□ Depressed mood	1 2 3 4 5 6 7	□ Self-harm (cutting, etc)	1 2 3 4 5 6 7
□ Tearful or crying spells	1 2 3 4 5 6 7	□ Bingeing/Purging	1 2 3 4 5 6 7

Are there any other symptoms that you are experiencing that were not listed? Please list._____

_____

Have you ever been sexually abused? □ yes □ no

Have you ever been physically abused? □ yes □ no

Have you ever been verbally abused? □ yes □ no

Have you ever witnessed or been involved in domestic violence? □ yes □ no

Did you grow up with someone who was a problem drinker, alcoholic or used street drugs? □ yes □ no

Did anyone in your family have a mental illness or attempt/commit suicide? □ yes □ no

Were your parents ever separated or divorced? □ yes □ no

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Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will speak to you, as I would to anyone who acknowledged me, but feel it appropriate not to engage in any discussions in public or outside of the therapy office.

In Case of Emergency

I provide counseling on an outpatient basis. I do not have an answering service and am not available at all times. It is my goal to return phone calls within 24 hours. If you need a therapist with 24-hour availability, I will discuss with you the options that are available. If you have a mental health emergency, please take one of the following actions:

- Call 911;
- Call Ridgeview Institute at 770.434.4567;
- Go to your nearest emergency room;
- Call Peachford Hospital at 770.455.3200.

About Robyn
I am a Licensed Professional Counselor in the State of Georgia (LPC#004847). I earned a Bachelor of Arts degree from the University of Oklahoma in 1982 and a Master of Arts in Marriage and Family Counseling from Southwestern Seminary in 1992. I am a Certified Professional Counselor Supervisor and supervise master's level interns and graduates who are working toward full licensure.

I am trained in EMDR (Eye Movement Desensitization Reprocessing) certified in Brainspotting and use a variety of techniques in order to help my clients heal and improve their lives.

Practice Policies

Payment for Sessions
The fee for my initial 60 minute counseling assessment is $200. The fee for follow-up sessions is $150 per 50-55 minute session unless otherwise negotiated. If you are interested in extended sessions, we can discuss my fee and availability to meet for longer periods of time. If you travel a long distance, depending on the work we are doing, I may be able to provide video counseling, if appropriate. Telephone sessions are the same rate as face-to-face counseling. If you need to talk to me between sessions, my availability will be limited and extensive conversations will not be possible.

Private Pay: The fee for your session will be due at the conclusion of each session. I accept cash, personal checks or credit cards as forms of payment. There is a $30 fee for any returned checks. If you are unable to pay for your session on the day of your appointment, the full balance will be due prior to your next session.

Insurance: If you plan to use your insurance to cover the cost of counseling, please call your insurance company to verify your behavioral health benefits and to find out the limitations of your particular plan. Please be aware that most insurance companies will not pay for sessions that are not considered "medical necessity." In other words, if your goal is personal growth and development, they will not pay. Each insurance plan has specific stipulations regarding payment for services. **If your insurance company denies payment for any reason, it is the client's responsibility to pay the account balance in full.**

If I am an in-network provider, my session fee has been set by your insurance company. As part of my contract with them, I have agreed that I will file a claim for the services you receive. If you have a deductible that has not been met, it is your responsibility to pay the full amount for the session each time we meet, until your deductible has been met. If your deductible has been met, or you have no deductible, you are only required to remit the copayment that has been set by your insurance company. I am an in-network provider with BCBS and TRICARE only. I am out-of-network with all other insurance companies.

If I am not a provider in your network, you may have out-of-network benefits that will cover a percentage of my fees. Please check with your insurance company to verify your eligibility. In this case, it is your responsibility to pay the full session fee. I will provide you with an invoice that you can submit to your insurance company for partial reimbursement or I can submit the claims for you electronically if you prefer.

Cancellation Policy
In the event that you are unable to keep an appointment, you must notify me at least 24 hours in advance. You will be charged the full session fee for missed sessions or those cancelled without 24-hour notice, except in cases of sudden illness or family emergency. **Please note that insurance companies will not reimburse for missed sessions and you will be responsible to pay the full fee for the session (not your co-pay).**

Use of Technology
There are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me that I maintain your confidentiality, respect your boundaries and assure that our relationship remains therapeutic and professional. Therefore, I have developed the following policies:

Cell phone

My cell phone is the primary means I use to communicate with clients, and seems to be the most common way clients communicate with me. As you may be aware, cell phones may not be completely secure and confidential. If you are uncomfortable with this means of communication, please discuss this with me.

Text Messaging and E-mail

Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text and/or email because it is a quick way to convey information. My phone and email are password protected and secure to the best of my ability. It is my policy to use these means of communication primarily for brief topics such as appointment cancellations or rescheduling. Texts or emails should never be used to communicate emergency information or therapeutic content.

Notice of Privacy Practices

I comply with HIPAA laws in protecting your private health information. The full notice of privacy practices is available on my website: www.robyngruberlpc.com/forms.

Please date and sign your name below indicating that the information you have provided is true to the best of your knowledge, that you have read and understand the contents of this form, that you agree to the policies of your relationship with me, and you are authorizing me to begin treatment with you.

_____ _____

Client Name (Please Print) Date

_____

Client Signature

If Applicable:

_____ _____

Parent or Legal Guardian Name (Please Print) Relationship to minor

_____ _____

Parent or Legal Guardian Signature Date

_____ _____

Parent or Legal Guardian Name (Please Print) Relationship to minor

_____ _____

Parent or Legal Guardian Signature Date

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____

Therapist Signature Date

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I acknowledge that I have received or have declined to read the Notice of Privacy Policies (HIPAA privacy policies) available on www.robyngruberlpc.com/forms. This notice outlines how I can and cannot use your private health information. Please discuss any questions or concerns you may have with me.

_____ _____

Client Signature Date

If Applicable:

_____ _____

Parent or Legal Guardian Name (Please Print) Relationship to minor

_____ _____

Parent or Legal Guardian Signature Date