Alice D. Hoag, Ed.D., LPC
185 Walls Complex Circle, Clarkesville, GA 30523
142 Forrest Ave., Gainesville, GA 30501
Phone: 706-768-9053 alice.hoag@hotmail.com www.hoagcounseling.com

ADULT PERSONAL INFORMATION

Name _____ Today's Date _____

Date of Birth_____ Age:_____ Email address*: _____

Home Address _____ City_____ ZIP_____

Phone Numbers: Home _____ Cell _____ Work _____

Please indicate whether I may leave a message: Home phone Y / N Cell phone Y / N Work phone Y / N

Calls will be discreet, but please indicate any restrictions: _____

*Note: I do not make appointment reminder calls, but you will receive email reminders 24-hours & 1 hour ahead.

Name of Employer _____ Occupation: _____

Address of Employer: _____ City_____ ZIP_____

Highest Education Completed (circle): Some High School High School Associates Bachelor Post Grad

Name & Address of Insurance Company _____

If you have mental health coverage through your health insurance company and your company is on my list of participating insurance carriers, please complete the Insurance Information Form if you wish me to file your claim.

Who referred you to this office? _____

If referred by a doctor or another clinician, would you like for us to communicate with one another? Y / N

Person(s) to notify in case of any emergency:_____Phone:_____

*Please note: 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 call if necessary: (Your signature):_____

Counseling Questions:

Have you ever received counseling or consulted a psychiatrist, psychologist or mental health professional? Y / N

If so, approximately when & with whom?_____

Did you find counseling helpful? _____

Reason you terminated counseling _____

Please briefly describe the main reason for your visit today? _____

_____

_____

What would your life be like if this problem were no longer an issue for you? _____

_____

What are your goals for therapy? _____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

Medical History:

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

_____

Previous medical hospitalizations (approximate dates and reasons):_____

_____

Previous psychiatric hospitalizations (approximate dates and reasons): _____

_____

Current medications (use back of form if more space is needed):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Approximate Height: _____ Approximate Weight: _____ Gender: _____

Briefly describe your diet and exercise patterns: _____

_____

Do you smoke or use tobacco? Y / N If yes, how much per day? _____
Do you consume caffeine? Y / N If yes, how much per day? _____
Do you drink alcohol? Y / N If yes, how much per day? _____
Do you use any non-prescription drugs? Y / N If yes, what kinds and how often? _____
Have any of your friends or family members voiced concern about your substance use? Y / N
Have you ever received treatment for past substance use? Y / N
Have you ever been in trouble or in risky situations because of your substance use? Y / N

Mental Health Symptoms:

Please indicate any symptoms you have experienced recently on a scale from 0 (never) to 5 (all the time/severe):

DIFFICULTY WITH		DIFFICULTY WITH		DIFFICULTY WITH	
Depression		Anxiety		Intense Fears	
Feeling Hopeless		Irritability		Nightmares	
Loss of Interest		Agitated/Restless		Feeling Numb/Detached	
Sleep too much		Fidgety		Easily Startled	
Sleep too little		Angry/Resentful		Obsessive Thoughts	
Excessive weight gain		Argumentative		Repetitive Behaviors	
Excessive weight loss		Dizziness		Overly Stressed	
Low Energy/Fatigue		Headaches		Visual/auditory hallucinations	
Memory Loss		Shortness of Breath		Sexual Concerns	
Poor Concentration		Chills or Hot Flashes		Domestic Violence	
Social Isolation		Heart Racing/Chest Pain		Financial Problems	
Grief		Muscle Tension		Legal Problems	
Mood Swings		History of Head Injury		Alcohol or Drug Use	
Episodes of Crying		Blackouts		Chronic Pain	
Thoughts of Death		Completing Tasks		Problems at Work	
Self Mutilation/Harm		Hyperactive		Problems at Home	
Suicide Attempt		Paying Attention		Problems with Friends	
Thoughts of Hurting Someone Else		Easily Distracted by Noise		History of Abuse/Neglect	

Family, Relationships, Social Support & Self-Care:

Mother's age (or age at death) _____ How would you describe your relationship with your mother?_____

_____

Father's age (or age at death) _____ How would you describe your relationship with your father?_____

_____

If alive, are your parents still married Y / N If they are divorced, how old were you when they separated or divorced, and how did this impact you? _____

Were there any other primary care givers who you had a significant relationship with? If so, please describe who and how this person impacted your life:_____

How many siblings do you have? _____ Ages/names? _____

How would you describe your relationship with your siblings? _____

_____

Briefly describe any history of abuse, neglect and/or trauma:_____

_____

Please indicate any significant stressors in the past 12 months:

Major losses: _____

Life changes: _____

Family stressors: _____

Work stressors: _____

Other: _____

Please indicate if there is a family history of any of the following (if there is, please indicate the family member's relationship to you: father, grandmother, uncle, sibling, etc): Alcohol/substance abuse, anxiety, bipolar disorder, depression, suicide attempts, trauma, domestic violence, sexual abuse, eating disorders, hyperactivity, learning disabilities, legal trouble, "nervous breakdown," obesity, obsessive compulsive behavior, schizophrenia.

_____

_____

Poor Excellent

Currently in a relationship? Y / N If yes, for how long? _____ Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? Y / N If yes, for how long? _____ Partner's Name_____Age_____

Occupation of partner _____ Employer _____

Previously Married/Life Partnered? Y / N If yes, length of previous relationship(s) _____

Do you have children? Y / N If yes, list names/ages: _____

Describe any problems any of your children are having: _____

_____

List the names/ages of those living in your household: _____

_____

Please list the names of those you consider your close friends who you can lean on in times of distress:

_____

What are some of your strengths? _____

What are some of your hobbies or interests? _____

Is spirituality important in your life? Y / N Please explain: _____

Do you actively participate in a place of worship? Y / N If yes, where?_____

Do I have your permission to pray with you during our sessions? Y / N

Final Question:

Is there anything else I should know about you and/or your circumstances before we begin our work together? If so, please specify: _____

_____

_____ _____

Signature (guardian, if client is unable to sign) (Date) 01/20

Financial Policy

To keep my fees as low as possible, I do not have staff to schedule appointments, file most insurance claims, or follow up with billing. Payment in full is due at the end of each session, unless insurance reimbursement has been verified prior to the session (see below). I cannot guarantee payment in part or in full by any insurance company or other third party, and therefore you are ultimately responsible for any charges you incur. I accept cash, local checks (payable to Alice Hoag), credit and debit cards. Please note that there is a $25 fee for any returned checks.

Usual and Customary fees:

Services eligible for insurance reimbursement (see "Insurance" section below):

- Initial Diagnostic Interview (60 minutes) @ $135/session, payable in full at time of booking
- 60 Minute Session for an established client @ $135/session

You will need to check with your insurance company to determine your co-pay or co-insurance amount. Your first session is payable in full so I can file your claim and determine what they will actually cover.

Services NOT eligible for insurance reimbursement (includes 25% discount for no insurance paperwork or claims):

- Initial Diagnostic Interview (60 minutes) @ $100/session, payable in full at time of booking
- 60 Minute Session for an established client @ $100/session

Life Recovery Groups, including Self-Compassion training, Couples Communication Training groups, Depression and Anxiety Management groups, and Divorce Recovery groups:

- 12-week, 2-hour groups @ $30/week ($360 prepaid at first session), maximum 8 people per group

Additional services not covered by insurance, and payable at the beginning of next session:

- Telephone Calls (Any call 5-15 minutes) @ $2.00 per minute from beginning of call
- No Show / No 24-hour Cancellation notice @ full session fee

Additional services not covered by insurance, which must be pre-paid at time of your written request/authorization:

- Report Preparation for schools, insurance, court, Social Security @ $150/hour, minimum 1 hour
- Court @ $150/hour including travel and preparation time, 8-hour minimum
- Deposition/Hearing services @ $150/hour including travel and preparation time, 8-hour minimum
- Face-to-face meetings with other professionals @ $150/hour including travel time, 2-hour minimum

Insurance:

Insurance Companies: I am a participating provider for the following insurance companies, and file claims for these companies only: Aetna/Coventry/MHNet, Alliant, Anthem/Blue Cross & Blue Shield, Beacon/Value Options, Cigna, Humana, Northeast Georgia Health Partners, Optum/United HealthCare, UMR

Please note: I cannot accept Medicare, Medicare Advantage, Medigap, or Medicaid insurance at this time.

If yours is not one of the above-listed insurance companies, I am not a preferred provider and you will need to proceed as a self-pay client. I can give you the paperwork you will need to file with your own insurance company, should you decide to do so.

Please contact your insurance company with any questions regarding your coverage and to obtain any necessary authorization numbers for counseling. Here are some questions to ask your insurance company:

- Do I have Outpatient Mental Health Benefits? If so, is Alice Hoag (Georgia license LPC#001803, NPI 1477724540) in-network or out-of-network?
- Does my plan cover the following billing codes (CPT codes 90791, 90834, 90837, 09846, 90847 and 96127) by a Licensed Professional Counselor?
- How many sessions per year does my insurance cover?
- Is preapproval or authorization required? If so, what is the authorization #?
- Which do I have:
  - A Copay? If so, how much will it cost me for each session of outpatient counseling with a Licensed Professional Counselor? $_____
  - A Deductible? If so,
    - How much is my deductible? $_____ (You will need to pay sessions in full, up to this amount)

- How much deductible is left before my co-insurance begins? $_____
- What is my co-insurance amount once I've met my deductible? _____%

Some employers provide an Employee Assistance Plan (EAP), which pays for 3 or more sessions at no charge to you. Knowing your insurance benefits is your responsibility. You can find out whether your employer has such a program by talking with your Human Resources department. If you do have EAP benefits, you will need to call your EAP directly to ask for an authorization for counseling. They will give you an authorization number, and will assign a counselor to you. (You may ask for me specifically by name, if you prefer.) Here are some EAPs which I participate in: All of the above insurance carriers plus American Behavioral, Concern, EAP Works, Espyr, FEI, LifeWorks/Morneau Shepell and Workplace Options.

Copays and deductibles. **All copays and deductibles must be paid at the time of service.** This arrangement is part of your contract with your insurance company, and your insurance requires that I collect a co-pay or co-insurance amount according to my contract with them. Failure on my part to collect co-payments and deductibles from patients can be considered fraud. Please help me in upholding the law by paying your co-payment at each visit.

Filing Claims: If you are a policyholder with one of the companies listed above, I have agreed with the insurance company to file the paperwork directly with them. Please keep in mind that payment remains your responsibility. I do not enter in disputes over insurance benefits. You agree to pay any portion of the charges not covered by your insurance. I file claims on a monthly basis. Your insurance company may need you to supply additional information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; I am not party to that contract.

Unfortunately, you will be unable to be reimbursed for Medicare or Medicaid, as I am not eligible to provide Medicare or Medicaid services at this time.

Coverage changes: If your insurance changes, please notify me before your next visit so I can make the appropriate changes with my insurance claims management company to help you receive your maximum benefits.

Missed Appointments, Late Cancellations and No-Shows:
In order to provide the best care and treatment to all of my clients, please give 24 hour notice if you are unable to make your appointment, in order to allow open appointments for others seeking treatment. **If such advance notice is not received, you will be charged the full fee for the session you missed.** Please note that insurance companies do not reimburse for missed sessions. Your scheduled appointment has been set exclusively for you. My availability is limited, and I often have a wait-list of clients wishing to see me sooner than my next available appointment. Since appointments cannot be scheduled sooner than 24 hours in advance, please be considerate of others who could have benefited from your missed appointment time.

__ I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments, deductibles and late cancellation fees are my responsibility. I agree to pay for all of these fees at the time of service.

__ I authorize my insurance benefits be paid directly to Alice D. Hoag, Ed.D., LPC.

__ I authorize Alice D. Hoag, Ed.D., LPC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____
Print Name of Client

_____ _____
Signature of Client (or responsible party if minor) Date

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Health Insurance Information

(Please note: Alice Hoag is NOT a Medicare or Medicaid provider at this time)

Name of Client_____ Date _____

Home Phone _____ Date of Birth _____

Home Address _____
(Street Address) (City) (State) (ZIP Code)

Relationship to the Insured (please circle): Self Spouse Child

Name of Insurance Company _____ Phone _____

Mailing Address for claims _____

Name of Insured _____ Home Phone_____ Date of Birth _____

Home Address _____
(Street Address) (City) (State) (ZIP Code)

Member ID/Policy Number _____ Group Number _____

Employer's Name _____

Please check and complete the **one** which applies to your insurance policy:

☐ Annual Deductible (amount you must pay before insurance starts to pay): $_____ , and
Co-insurance (percentage of the fee you are required to pay after meeting your deductible) _____%

☐ Co-pay (flat amount payable instead of meeting a deductible and coinsurance): $_____

Other (secondary) Insurance Company _____

Mailing Address for claims _____

Name of Insured _____ Home Phone_____ Date of Birth _____

Home Address _____
(Street Address) (City) (State) (ZIP Code)

Member ID/Policy Number _____ Group Number _____

Employer's Name _____ Relationship to Insured _____

I authorize my insurance benefits be paid directly to Alice D. Hoag, Ed.D., LPC for services provided. I understand that I am responsible for all charges I incur if my insurance contract does not cover them.

I authorize Alice D. Hoag, Ed.D., LPC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____ _____
Signature of Client Date
(or responsible party, if client is a minor)

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CONSENT & AUTHORIZATION TO COORDINATE TREATMENT

If you are on prescription medication or are under the care of a personal physician, psychiatrist, or other counselor, it will be essential to have all your specialists coordinate your treatment. The following is an authorization for two-way communication between Alice Hoag and your other physical and/or mental health provider(s). Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below. Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

****

I, _____ (client), whose date of birth is _____, hereby authorize Alice D. Hoag (therapist) and the following party or parties to discuss my mental health treatment information and records obtained in the course of my treatment:

(1) _____ (Phone) _____

(2) _____ (Phone) _____

Information to be disclosed (initial each item to be disclosed):

___ Assessment
___ Diagnosis
___ Psychological Evaluation (from PhD only)
___ Psychiatric Evaluation (from MD only)
___ Treatment Plan or summary
___ Medication Management Information
___ Medical Information (from MD only)
___ Presence / Participation in Treatment (summary)
___ Progress in Treatment (summary)
___ Other _____

Please indicate your preference regarding the information to be shared:

___ The parties stated above may discuss my medical and/or mental health information without limits

___ I would prefer to limit the information shared between the parties stated above, as follows:

_____

Additionally, the above-named parties, therapist, and person(s) or entity (entities) designated under (1) or (2) agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates you understand you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that you have the right to revoke this authorization in writing at any time. Additionally, if you decide to revoke this authorization, such revocation must be in writing and will be effective on the date received by the above-named therapist at the above addresses. If you wish to revoke this form in person, please call first so I may have it ready when you come by.

Client's Signature: _____ Date: _____

Parent's/Legal Guardian's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

****

I revoke this authorization effective_____ Date: _____ 12/19