INTAKE FORM

(Please Print)

Today's Date _____/_____/_____ **Consultant_____**

Client Information:

Client's Last Name	**First**	**Middle**	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code		Home Phone No. ( )
P.O. Box	City	State	ZIP Code		Cell Phone No. ( )
Occupation	Employer				Work Phone No. ( )

Referred to Recovery Cafe by: ❑ Psychology Today ❑ Dr. _____ ❑ Insurance Plan ❑ Website

❑ Family ❑ Friend ❑ Internet Search ❑ Phone Book ❑ Other _____

Email Address:	Alternative Email Address:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at the same address)	Relationship to Client	Home Phone No.	Work Phone No.

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be accountable for fully paying fees for services rendered.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Athens, GA 30606
Alpine, WY 83128
Driggs, ID 83452

Email: athensrecoverycafe@gmail.com **Website:** www.recoverycafe.com

IMPORTANT INFORMATION AND CLIENT CONSENT:
Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: Recovery Cafe has a relationship directed at lifestyle change and a greater sense of contentment for you.

AVAILABLE SERVICES: Recovery Cafe offers individual, family, couples, and group services. It is affiliated with skilled, experienced and licensed professional counselors, marriage and family counselors, licensed clinical social workers, Doctor of Psychology, psychiatric physicians, addictionologists, addiction counselors, trauma treatment providers, and alternative health care providers.

RISKS AND BENEFITS: Counseling and psychotherapy are usually beneficial. There are inherent risks. During counseling, you will have discussions that may elicit uncomfortable emotions. Increased symptoms of depression and anxiety may show up.

Your first visit is a consultation to discuss your strengths and treatment goals, what has helped you achieve previous goals, how your skills and attributes were helpful then and how they may be beneficial in the present. Recovery Cafe will work toward your preferred future using the strengths and resources you have identified. If you feel that Recovery Cafe is not a good fit, please discuss this with Recovery Cafe, as this is a critical variable in your success. Recovery Cafe will not be offended and will assist you in finding a provider that is a better fit for you.

APPOINTMENTS: Appointments are scheduled and 50 minutes long. If you must cancel or reschedule your appointment, text or email Recovery Cafe at least 24 hours in advance to free your appointment time for another patient. If this does not happen, Recovery Cafe will bill you at the total rate for the missed session which must be paid at the time of the next meeting.

FEE SCHEDULE:	Initial Consultation (1st visit, 90 minutes)	$150
	Regular Office Visits (50 minutes)	$125
	Family Sessions (90 minutes)	$200
	Alcohol & Drug Evaluation	$250
	Written Reports	$50

PAYMENT/INSURANCE FILING: All billing is conducted online via invoice. A credit card authorization form is included, allowing your card to be kept on file. For clients paying per session, your card will be charged on the morning of your session, and you will receive your payment. For groups that meet twice per week, billing

occurs on the Monday of each week you are enrolled in the group. Recovery Cafe offers a 10% discount for all total payments of a program. You can prepay for a month or four weeks for individual general counseling to receive this discount. Otherwise, you will receive either a receipt or an invoice on the day of your session. Clients who choose not to have a card on file will be billed the day before their session.

PHONE CALLS & PHONE SESSIONS: Recovery Cafe primarily operates online and offers phone sessions as part of our services. A separate consent form is included specifically for telehealth, where you can learn more about the modalities and details.

CHANCE MEETINGS IN PUBLIC AND SOCIAL MEDIA: There are chances Recovery Cafe may encounter you in public or on social media platforms. Recovery Cafe does not publicly acknowledge or approach clients or engage with them on social media due to ethical and privacy concerns. If you approach Recovery Cafe in public, we will speak generally about the current surroundings. You are welcome to follow us on social media, but Recovery Cafe cannot address or respond to any posts you make.

By signing this Information and Consent Form, you understand and agree to the abovementioned terms.

Name _____ Telephone Number _____

_____ _____

INCAPACITY OR DEATH: Recovery Cafe understands that, in the event of the death or incapacitation of your therapist, you may choose to find another therapist. That therapist may have possession of Recovery Cafe's treatment records. By signing this form, you hereby consent to another licensed mental health professional selected by you to take possession of Recovery Cafe's records related to you.

CONSENT TO TREATMENT: Recovery Cafe acknowledges that it has read, understands, and agrees to the terms and conditions. Recovery Cafe has been allowed to address any questions or request clarification for anything unclear. Recovery Cafe has been given an opportunity to read the HIPPA policy for your practice, is voluntarily agreeing to treatment and services for itself (or its ward if said ward is the client) and understands that it may stop such treatment or services at any time and will pay its outstanding fees in full at that time.

_____ _____

Signature – Client/Guardian Date

_____ _____

Signature – Spouse/Partner/Parent Date

_____ _____

Therapist Date

Athens, GA 30606
Alpine, WY 83128
Driggs, ID 83452

Email: athensrecoverycafe@gmail.com **Website:** www.recoverycafe.com

Recovery Café Telehealth Consent Form

Introduction

This Telehealth Consent Form is provided to ensure that you, as a client of Recovery Café, fully understand and consent to participate in telehealth services. Telehealth services include the delivery of health care and psychotherapy via modern communication technologies, such as video conferencing, telephone communication, and electronic messaging.

Consent to Telehealth Services

- Nature of Telehealth Services:
  - You hereby consent to engage in telehealth as the primary mode of therapy.
  - Telehealth involves using interactive audio, video, and/or data communications to provide and support health care at a distance.
- Confidentiality and Security:
  - The confidentiality of all communications and records about your therapy will be maintained as per applicable legal standards.
  - All information disclosed within sessions and the written records about those sessions are confidential and will not be shared without your written consent, except where mandated or permitted by law.
- Potential Benefits and Risks:
  - Benefits include improved access to therapy, convenience, and receiving services in the comfort of your home.

    - Risks could include but are not limited to, occasional disruptions in the service due to technical issues and the potential for security breaches despite best efforts to maintain high data protection standards.

- Client Rights:
    - You have the right to withhold or withdraw consent at any time without affecting your right to future care or treatment.
    - You have the right to ask questions about any aspect of telehealth services at any time.
- Therapist Responsibilities:
    - Recovery Café ensures that all telehealth engagements are conducted professionally, following ethical and best practice guidelines.
    - We will use technology systems that enhance privacy and confidentiality to the greatest extent possible.
- Emergency Protocols:
    - In the case of an emergency arising during a telehealth session, you should be prepared to provide your location and local emergency service contact details.
    - Recovery Café is not an emergency service provider. In the event of an acute crisis, please contact emergency services immediately.

Consent Agreement

By signing this form, I acknowledge that:

- I have read and understand the information provided above regarding telehealth, have discussed it with my therapist or a staff member at Recovery Café, and all my questions have been answered to my satisfaction.
- I hereby give my informed consent to participate in telehealth services under the terms described herein.

Signature:

Patient's Signature: _____
Date: _____

Patient's Printed Name: _____

Release of Information Form

Patient/Client
Name:_____DOB:_____
_____

Information to be released or exchanged from:

Name: __Steve Patterson_____ Organization: Recovery Cafe____
_____

Address: Mars Hill Road, Athens, GA
_____

Phone: (706) 369-0970_____ Email:
recoverycafeathens@gmail.com

Information to be released or exchanged to: (Third party such as attorney or otherwise)

Name: _____Organization:
_____

Address:_____
_____

Phone:_____
Email:_____

Information to be released or exchanged:

___History & Physical Exam
___Discharge Summary
___Psychiatric Evaluation
___Psychological Testing
___Court /Agency Documents
___Mental Status
___Treatment Plans
___Progress Notes
___Alcohol/Drug Evaluation
___Grades & School Records
___Consultation Reports
___Educational Tests/Reports

___Chemical Recovery History	___ Lab Results	___Attendance Record
___Dates of Hospitalization	___Diagnoses	___Psychosocial Report
___Crisis Intervention Reports	___Medical Records	___ **ALL – By checking this box, you authorize all these options.**
Other:_____	Other:_____	Other:_____

Disclosure of this confidential information may be made only as necessary for furthering and delivering treatment or as directed by me. This release may occur verbally, in writing or via telephone, email or facsimile. I agree that this release will be valid for one year of the signed date unless otherwise noted and can be revoked by written means.

Patient
Signature:_____Date:_____
_____

Parent/Guardian
Signature:_____
_

Credit Card Authorization

I, the undersigned, agree to pay The Recovery Cafe for the provision of Treatment for me or the person(s) listed below, for whom I accept full financial responsibility.

I authorize RC to keep my signature on file and to charge my credit card

_____ _____

Authorized Signature Date Client Date

CREDIT CARD INFORMATION

Check one: ☐ VISA® ☐American Express® ☐ MasterCard® ☐ Discover® Card

Cardholder Name: _____

Billing Address: _____

City: _____State: _____ Zip: _____

Credit Card Number: _____ CCV_____Expiration Date: _____

Cardholder Signature:_____ Date: _____