MOVING FORWARD LIFE SERVICES

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CLIENT INFORMATION

Client's last name: First: Middle:			Date:	Phone No.
Street Address:	Social Security:	Birth date: / /	Age:	Gender:
P.O. Box:	City:	State:	ZIP Code:	
Emergency contact Name:	Relationship to patient	Phone no:		
Child's PCP:	Physicians Address	Physicians Phone no:		

INSURANCE INFORMATION

Insurance Name:	Policy Holder Last Name:	Policy Holder First Name:	D.O.B.
Primary Insured ID:	Employer:	Employer Phone no:	
Subscriber's ID:	Subscriber's S.S. no:	Plan Name:	Group no:	Policy no:
Name of secondary insurance:	Guarantor:	Last Name:	First Name:

DEVELOPMENTAL HISTORY

Diagnosis: Code:	Secondary Diagnosis:	Doctor Assigning Diagnosis:	Is your child seeing any specialist? Y ☐ N ☐ If yes what type?
What previous therapy has your child received & how did he/she respond?			
Please describe child's milestones developments:			
What goals would you like to be addressed with the ABA services?			
Does your child receive any other services? Y ☐ N ☐	If yes can we collaborate with the services provide? Y ☐ N ☐		
Please list services:			
What positive developments do you see in your child's development?			
What challenges do you face with your child?			
What maladaptive behaviors does your child exhibit?			
Is your child attending any educational day program? Describe			

Parent/Legal Guardian Signature: Date:

By signing above I acknowledge the I have read and received a copy of your Notice of Privacy Practices.

MOVING FORWARD LIFE SERVICES, LLC Date: _____

Last Name _____First Name _____
MI _____

Address

_____

City _____ ST _____ Zip _____

Home Phone _____Work Phone _____
Cell Phone _____

May we call you or leave a message for you at – Home ☐ Your Work ☐ Your Cell ☐

Birth Date _____ Age _____ Email _____

Marital Status: S____ M ____ D ____ P ____ # of year's _____

Spouse/Partner's Name _____

Race/ethnicity _____ Educational Level _____

Responsible Party: Name _____
Relationship to Client _____

Name of person to contact in the case of an emergency

_____

Phone #

_____

How did you hear about Moving Forward Life Services?

_____

Employment Information

2362 Main ST. Ste B * Tucker, GA 30084
Phone: 678/ 634-7594

MOVING FORWARD LIFE SERVICES, LLC Date: _____
Employer

_____

Address _____City _____ ST_____
Zip _____

Phone # _____
Employed: Full Time ☐ Part Time ☐

Length of time in current position _____
Current Job Title _____

Do you enjoy your work? Yes _____ No _____

Can we send you information about Moving Forward Life Services through your email address ☐ Y ☐ N

FINANCIAL AGREEMENTS, POLICES, PROCEDURES AND CONSENTS

Fees

The fees for the initial sixty minutes session is $125.00, each additional fifty-minute session is $80.00, which is payable at the time of each appointment, unless other arrangements are made. You can make payment with cash, check, or credit/debit card.

Appointments, Cancellations and No-Shows

At the conclusion of your initial interview you and your counselor may agree to schedule for additional appointments. Because consistency is an important part of the counseling process, the

appointment time you schedule is reserved for you and is not available to anyone else. If you are unable to keep a scheduled appointment, you must notify the Center at least **24 HOURS** in advance to avoid having to pay for the canceled or missed appointment. Insurance will not pay for missed appointments; therefore you are responsible to pay a minimum fee of **$40.00** as contracted with the Center.

INSURANCE INFPRMATION

Primary Insurance Insured is: Self _____ Spouse _____ Child _____ Other _____

Name/Date of Birth

_____

Secondary Insurance Insured is: Self _____ Spouse _____ Child _____ Other _____

Name/Date Birth

_____

Insurance

Although you are ultimately responsible for your fee, health insurance may pay a portion of the charge. At your request the Center's office staff will contact your insurance company regarding the benefits for our services and will also file your claims.

MOVING FORWARD LIFE SERVICES, LLC Date: _____

If your annual deductible has been met it may be possible for you to pay only your portion of the fee and for the insurance company to pay the balance to the Center. If the deductible has not been met you will be responsible for paying the full fee until the deductible has been satisfied. Co-pays are due at the time of your session.

Signature _____ Date _____

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PRESENTING PROBLEM (current situation and history)

1. What us the primary problem for which you are seeking help? (please circle)

a. Marriage or relationship	g. Problems with children	m. Grieving
b. Family Problems	h. Peer problems	n. Abuse or trauma
c. Depression	i. Eating disorder	o. Sexual functioning
d. Mood swings	j. Alcohol/drug use	p. Anger
e. Behavior	k. Physical problems	q. Anxiety or worry
f. Self-Confidence	l. Work related	r. Other (explain):

_____

_____

_____

2. How long have you had this/these problem(s)? _____

3. Have you received treatment for this problem or any other problem in the past? ☐ Yes ☐ No
   If yes when, where and with whom? _____
   _____

FAMILY HISTORY

1. Were drugs or alcohol a problem in your family when you were growing up? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

2. Do you or another family member have a history of alcohol or drug problem? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

3. Please describe your current alcohol consumption: _____
   _____

4. Was there any type of abuse (physical, sexual, domestic or emotional) in your family or home?
   ☐ Yes ☐ No If yes, please describe the circumstances: _____
   _____

5. Have you or any other family member experienced any type of abuse? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

LEGAL HISTORY

Please describe any involvement you have had with the legal system (arrests, convictions, probation, parole): _____
_____
_____

CURRENT FAMILY INFORMATION:

1. Please provide the following information:

Name (First and Last)	**Date of Birth**	**Lives with You?**
Spouse/Significant Other:		☐ Yes ☐ No
Children:		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
Others Living in the Household:		

2. Military service: ☐ Yes ☐ No

3. Occupation: _____

4. Current employer: _____

MEDICAL HISTORY

1. Primary Care physician/pediatrician: _____

2. Please check the appropriate box if you have experienced any of these problems:

☐ Head Injury ☐ Convulsions or seizures ☐ Sleep Disturbances
☐ Memory Problems ☐ Extreme tiredness or weakness ☐ High blood pressure
☐ Eating Disorder ☐ Cancer ☐ Loss of consciousness
☐ Frequent or severe headaches

Have you had/or clear of COVID-19 ☐ Yes ☐ No

Please explain anything checked above: _____
_____

3. Please provide information about medication(s), prescription or over-the-counter, which you take regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): _____
_____

GOALS

1. What are your strengths? _____
_____

2. What are your weaknesses? _____
_____

3. What goals would you like to see reached as a result of your involvement with Moving Forward Life Services?

_____
_____
_____
_____

4. How will you know when these goals have been reached?

_____
_____
_____
_____

Therapist Review

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

The privacy of your Protected Health Information is very important. Please read thoroughly and sign this as notice of how your information may be used and disclosed and how you may access the information.

Moving Forward Life Services (MFLS) and its affiliates are required by applicable federal and state laws to maintain the privacy of your protected health information (PHI). PHI is information that may identify you and relates to your past, present, or future physical or mental health/condition and related health-care services. We will not use or disclose PHI without your written authorization – except as described in this notice.

We are required to give this notice about your privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect.

This notice took effect on September 1, 2006 and will remain in effect until replaced by the agency. We reserve the right to change our privacy practices and the terms of this notice at any time – provided such changes are permitted by applicable law. In the event, we make a material change in our privacy practice; we will change this notice and provide it to you.

MFLS uses and discloses protected information about you for treatment, payment, and healthcare/program operations as follows:

1) **In addition to our use of your PHI for treatment, payment, or healthcare/program operations you may give us** written authorization **to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time (except where required by Court-ordered services). You revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.**

2) **We may use or disclose your PHI to the referral source for purposes of** treatment **planning and coordination, reporting compliance/non-compliance issues, and referral to another additional service provider.**

3) **We may use or disclose your PHI to obtain** payment **for services we provide to you. This may include such activities as verification of coverage and billing/collection activities and related data processing.**

MFLS may use and disclose your PHI in connection with our healthcare program operations. This may include such activities as quality assessment and improvement activities, reviewing the competence and/or qualifications of healthcare/program professionals, evaluating provider performance, conducting training programs, and accreditation, certification, licensing and/or credentialing activities.

Helping People to Move Forward in Life
2362 Main Street. • Suite B • Tucker GA 30084
Office: 770-939-5800 • Fax: 770-708-7933
www.movingforwardlifeservices.com

As required by law, MFLS may use or disclose your PHI when we are required to do so by law – including judicial and administrative proceedings.

MFLS may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may also disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others – including, if we have good reason to believe that you are engaging in child abuse.

MFLS may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of PHI under certain circumstances

MFLS may use or disclose your PHI to provide you with appointment reminders or to advise you that you are at risk for program termination. Such activities may include voicemail messages and letters.

By signing below you acknowledge that you have read and understand the above statements regarding Moving Forward Life Services privacy practices and that you have received a copy of this HIPPA form.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

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