ANCHOR POINT

Counseling, Biofeedback, Neurofeedback & Integrative Medicine
3320 Old Salem Road, Conyers, GA 30013
Phone (678) 210-1166 Fax: (678) 210-0177
doctors@anchorpointga.com

CLIENT INFORMATION FORM

Date:	Client Social Security #:
Client Name:	Sex: Male Female (please circle one) Marital Status: S M D Other (please circle one)
Client Address:	
City:	Zip:
Phone/home:	Phone/cell:
Phone/work:	Fax:
Phone/other:	**Email address**:
Client Birthdate:	Employed, Full-time Student, Part-time Student, Retired, Other (please circle one)
Client Employer or School:	
Spouse or Parent Name:	Birthdate:
Spouse or Parent Employer:	Cell Phone #:
Emergency Contact: Relationship:	Phone #:
Client's Primary Care Physician:	Phone #:
Referred to Anchor Point by:	How did you hear about us?
Goals:	

RESPONSIBLE PARTY INFORMATION

If Patient is a Minor

Payor/Parent Name:		
Payor/Parent Address:		
Payor/Parent Phone # :	Wk phone #:	Fax #:
Payor/Parent Employer:		

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RELEASE OF INFORMATION

1) I authorize M. J. Kassam, MD, Susan Sendelbach, M.A, D. Min., Patricia Liggett, CHAM and/or Peder Fagerholm, Ph.D. to disclose my health care information for the purpose of billing and obtaining payment. Additionally, for the purpose of training, supervision, and where mandated by law some information may be shared.
2) I understand that if I do not pay according to this agreement, all legal and collection fees are my responsibility. There is a late fee of $15.00 if payment is not received by scheduled date.

PRIVACY POLICY

My signature below indicates that I am aware of Anchor Point's Privacy Policy and it's available for my review. I wish **not to be contacted** the following way: (Example: Home, Work, Cell)

☐ _____ ☐_____ ☐_____

CLIENT RESPONSIBILITIES

Neurofeedback training, QEEG, and psychospiritual therapy are the services offered by Anchor Point. I authorize the use of appropriate touching for therapeutic healing, and application of biofeedback sensors if utilizing Neurotherapy sessions. By signing below, I understand that achieving my goals is a mutual relationship with the therapist or trainer. Success is not guaranteed and is determined by the effort that I put into our time together with the therapist/trainer serving as my guide or coach. I will notify my therapist or trainer of any changes in my medications or health condition.

I agree to pay for sessions at the time of the visit, and in respect for the therapist/ trainer's time I agree to pay $75 for sessions that are cancelled with less than 24-hr. notice and a full session fee for missed appointments when no notice is given. I may terminate the relationship at any time. It is requested however that the ending of psychospiritual therapy be discussed in person and followed by at least two more sessions to facilitate a healing atmosphere of closure for all parties. The patient/therapist relationship will be considered terminated; by the patient, when patient does not schedule a new appointment after three months. I also agree to pay the full replacement cost of any furniture or equipment, if any item is damaged or broken by me or any of my family or visitors.

_____ **Date**_____
Signature of Adult Client or Responsible Party **Print Name**

Relationship to Client_____

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SERVICES AND PRICE AGREEMENT

Office sessions:

- Sessions are one hour long, sessions going beyond the hour will be pro-rated
- Clients cancelling appointments with less than 24-hour notice are billed $75.00
- Clients missing appointments without calling or leaving a message may be charged the full cost of session
- Client is responsible for all collection and court costs associated with unpaid balances
- The cost of copying records is $1 per color page and 50¢ per black and white page
- The fees for making court appearances, travel time and time spent reviewing materials, writing reports, summaries, and letters will be billed by the full hour and are due at time of service. Court costs are prepaid for the full day
- Telephone consultations and counseling will be provided at a pro-rated hourly rate
- The fee for checks returned for non-payment or a credit charge denial will be $30.00 using Check Track system
- Collect telephone calls will not be accepted
- **Counseling session fee is $100-$150 – Neural therapies are $120-$170**
- QEEG Brain Mapping fee is $450, once online access is granted client will have three weeks to complete – **NO REFUNDS FOR BRAIN MAPPING NOT COMPLETED WITHIN TIME LIMIT.**

Overtime: Sessions that extend beyond the hour allotted will be charged a pro-rated rate for the addition time

If I am late for a session, I understand that the session hour will begin when I arrive but will end at the same agreed upon session hour time in consideration for the trainer/therapist and other clients. If I expect to be late, I will attempt to call the therapist. Otherwise, the trainer/therapist will attempt to call me 10 minutes after the session time. If I cannot be reached, the session will be assumed to be a missed appointment, and the trainer/therapist is not expected to wait for me. If I wish to have an extended training or counseling/consultation session I will request that additional time in advance of the session. If the therapist/trainer is late for my session, I will be given the full hour session.

No refunds are given for services that have already been performed or that require pre-payment (QEEG's)

WE ASK THAT PAYMENT BE MADE AT THE TIME OF EACH OFFICE VISIT or; for your convenience, we can retain your credit/debit card information and charge you weekly for the session. If you would like us to do so, please complete the credit card authorization form attached, please note cards cannot be locked when charges are run.

WE ACCEPT THE FOLLOWING: American Express, Discover, Master Card, Visa, Cash, Check, or Visa Debit

TECHNOLOGY BASED COMMUNICATION

Please be aware that client initiated communications via text messaging and/or email **are not 100% confidential**. Phone and internet service providers retain logs of messages, content, and location services which may be accessible to unknown persons. Should you choose to contact our office via text or email we will reply; if requested, **only** should you indicate by initialing **here**:_____

I have reviewed, understand, and agree with the Client Notifications, Client Responsibilities and this Services and Price Agreement.

_____ _____

Signature of Adult Client or Responsible Party **Date**

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CREDIT CARD AUTHORIZATION

BEGIN DATE: _____ END DATE:_____

CARD: VISA MASTERCARD DISCOVER AMEX
DEBIT (VISA/MASTERCARD)

PATIENT NAME_____

CARD #_____

EXPIRATION DATE: _____

SECURITY CODE: _____

NAME ON CARD: _____

ID VERIFICATION: YES_____ NO_____ (initial confirmation)

CARD HOLDER ADDRESS: _____
ZIP CODE: _____

CARD HOLDER EMAIL ADDRESS: _____

I _____, do hereby authorize the amount of

$_____ be charged to the above indicated account by Anchor Point Inc. after each session or on Friday's. I further authorize Anchor Point to charge the late cancellation fee as explained in "Services and Price Agreement". I understand that I can revoke this authorization at any time and will not lock the card to prevent usage as arranged.

Authorized Signature: _____

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Client History

(Please complete fully; Use back for additional space)

Name: _____ Date: _____

Height_____ Weight_____

Briefly describe the reason for your visit: _____

_____

_____

How long have you had this concern: _____

Prior treatment for this concern: _____

_____

What are your strengths/special interests/activities: _____

_____

Current Medications: (include over the counter medications, vitamins, herbal, and illegal drugs)

_____

_____

Do you drink beer, wine or liquor? ☐Yes ☐No Frequency: _____

Provide a recent medical and social history: _____

_____

Provide a brief family medical history: _____

_____

Name and ages of family/friends living with you:

_____ _____ _____

_____ _____ _____

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CLIENT NOTIFICATIONS

The Client or the Payor is responsible for all charges.

Please be prompt for your scheduled session. If you expect to be late, please attempt to call the therapist/trainer at 678-210-1166. Email is not an accepted means for changing your appointment or cancelling. If you are late, the session hour will begin when you arrive, but it will end at the previously scheduled time. If the therapist/trainer is late for the session, you will be given the full hour session.

Anchor Point is staffed by a psychotherapist licensed to provide Neurofeedback and Biofeedback, and an M.D., Medical Doctor, who consults and oversees therapy.

Please tell your therapist/trainer of any circumstances in your life that may affect your scheduled session. Illness, celebrations, grief and loss, no matter how small or large, can affect the session.

Anchor Point strives to be a "safe haven" for our clients. To maintain healing atmosphere weapons are not permitted on the premises.

If you are late, the therapist/trainer will attempt to call you ten minutes after the session starts. If you cannot be reached, the session will be assumed to be a missed appointment, and the trainer/therapist is not expected to wait for you. If you know that you need to cancel a session, please call Anchor Point as soon as possible so that your time slot can be filled by someone else. **You will need to pay $75 for sessions that are cancelled with less than 24 hour notice; a minimum of $75 is due if you miss an appointment without notice**. Full charges for the hour or procedure may be charged for missed sessions. You may terminate training or counseling at any time, for any reason, by informing us at 678-210-1166.

If you are paying by check or charge/debit card, there will be a $30.00 fee through Check Track **for** any returned check for non-payment or any charge card payment that is not accepted. Legal action may be taken to collect on any account that is more than ninety days overdue, unless Anchor Point agrees to an alternative payment plan with you in writing. Late fees and interest fees will apply on all invoices. If your account is turned over to Collections or to the courts, courtesy adjustments and sliding scale reduced rates will not apply. There will be an additional charge of 5% interest per month plus costs of filing, expenses, and attorneys.

Most children require 40 or more-hour sessions to complete Neurotherapy and most adults require at least 30 hour sessions. It is possible for some clients to finish earlier or to have particular needs that require longer training. Clients with difficult or long-term conditions may require 80 or more sessions. The number of sessions for counseling varies by the individuals and there is no pre-set recommended number of sessions. Goals are set between client and therapist.

Anchor Point's policy for Privacy Practices is available at the front desk for your review. Please let Anchor Point know if there are any changes in your address, phone number, or other information. Feel free to ask any questions about your treatment plan.

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Evaluation Checklist

CLIENT: _____ **DATE:** _____

COMPLETED BY: _____ **AGE:** _____

0 means "I consider this NOT an issue."
1 means "I consider this SOMETIMES an issue."
2 means "I consider this OFTEN an issue."
3 means "I consider this a MAJOR issue"

	Speaks or acts impulsively
	Distracted by noises or movements
	Misses cues in social situations
	Active or energetic or fidgety
	Difficulty falling asleep or restless sleeper
	Quick emotional responses
	Speaks quickly or loudly or interrupts
	Allergies or asthma
	Clumsy or accident prone
	Impatient, seeks stimulation, easily bored
	Messy handwriting
	Rushes tasks, makes silly mistakes
	Night sweats or bedwetting
	Drifts off into thoughts or daydreams
	Shy or withdrawn in social situations
	Difficulty waking up or sleeps deeply but is not rested
	Feels helpless or hopeless or cries easily
	Speaks quietly or slowly
	Procrastinates starting tasks
	Quickly forgets tasks or learned material
	Difficulty with reading, listening, writing for detail
	Difficulty completing tasks with multiple steps
	Apathetic or indifferent or seems lazy
	Loses focus when reading or listening
	History of early abuse
	Distant or absent parents early in life
	Paranoid thoughts
	History of anxiety and/or depression

	Thinks about death or suicide
	Sleepwalking or night terrors
	Feels guilty or ashamed
	Explosive emotional reactions to minor events
	Repressed or intrusive memories
	Flat emotional response to positive events
	Difficulty sustaining intimate relationships
	Sometimes can't recall periods of time
	Oppositional/defiant
	Hyperfocuses or has difficulty changing tasks
	Argues frequently; doesn't give in
	Rigid thought; gets stuck on an idea
	Compulsive behaviors
	Difficulty balancing multiple tasks or assignments
	Repeats words/phrases over and over
	Phobias or irrational fears
	Holds a grudge or dislikes change
	Tics/involuntary movements or noises
	Obsessive thoughts or fears
	Addictive behaviors
	Perceives events negatively
	Grinds teeth
	Wakes shortly after sleeping and can't sleep again
	Relatively constant anxiety
	Anger outbursts after slow build-up
	Productive but gets worn down by workload
	Demands perfection of self and others
	Frequent tension headaches

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Evaluation Checklist (Page 2)

CLIENT: _____ **DATE:** _____

COMPLETED BY: _____ **AGE:** _____

0 means "I consider this NOT an issue."
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3 means "I consider this a MAJOR issue"

	Highly detail oriented or structured
	Difficulty with creative tasks
	Easily agitated
	Dominant or demanding in relationships
	Migraines or Irritable Bowel
	Chronically fatigued
	Low energy level and depressed or flat feelings
	Cold hands/feet
	Panic attacks
	Sweaty palms or excessive sweating
	Bloating after eating or stomach rumbling
	Chronic difficulty with sleep
	High blood pressure
	Racing heart beat
	Difficulty catching breath or shallow breathing
	Dizziness or light-headedness
	Sensitivity to touch, light or sound
	Aggressive anger or irritability
	Seizures
	Outbursts of rage without cause
	Closes off to sensory awareness
	Does not like to be touched or held

Please list any additional items you would like to add:

_____

_____

_____