PROGRESSIVE CONSUMER COUNSELING SERVICES
6175 Old National Hwy, Suite 420, College Park, GA 30349 | 404-209-1209

Start Services: Paper Intake

Prefer paper? Print this packet at actual size on US Letter paper, complete it by hand, and sign the consent pages. You do not need to submit the online form as well.

Bring your completed packet to our office, or call 404-209-1209 to arrange a secure return method. Do not send sensitive health information through ordinary email. Ask our team about any consent you do not understand before signing.

Complete the sections that apply to you; write N/A where appropriate. Include your name on each page. This packet is not monitored for emergencies: call 911 for immediate danger, or call/text 988 for crisis support.

Full legal name

Date of birth Phone

Email

Mailing address (optional)

State of residence ZIP code

Social Security number (optional)

Emergency contact name Emergency contact phone

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Primary Coverage

Patient name

Select your primary coverage:

- ☐ Medicaid
- ☐ Medicare
- ☐ Private insurance
- ☐ Self-pay (no insurance)

For Medicare or private insurance:

Insurance company Member ID / policy number

Group number (if applicable)

Policy holder name Policy holder date of birth

Relationship to patient:

☐ Self / Parent / Spouse / Other: _____

For Medicaid:

Medicaid ID number

Medicaid plan:

☐ Amerigroup Medicaid / CareSource Medicaid / Other or not sure

Care Management Organization (CMO) assigned?

☐ Yes / No / Not sure

Behavioral-health services in the past 12 months?

☐ Yes / No

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Secondary Coverage & Authorizations

Patient name

Do you have secondary insurance?

☐ Yes / No

Complete below only if you have secondary coverage:

Secondary insurance company

Secondary member ID

Secondary policy holder name

Policy holder relationship to patient:

☐ Self / Parent / Spouse / Other: _____

Insurance authorizations (for Medicaid, Medicare, and private insurance). Check each statement you agree to:

☐ I authorize Progressive Counseling to verify my insurance eligibility.

☐ I authorize Progressive Counseling to bill my insurance for services provided.

☐ I understand I may be financially responsible for any non-covered services or unmet copays/ deductibles.

Patient / authorized representative signature Date

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Medical Snapshot & Reason for Seeking Care

Patient name

Primary care physician

Current medications

Allergies

Chronic conditions

What brings you in? Describe the support you are seeking.

In the last two weeks, I've had thoughts of harming myself.

☐ Yes / No

I've had thoughts of harming someone else.

☐ Yes / No

Do not wait for this packet to be reviewed if you need immediate help. Call 911 for immediate danger, call/text 988, or call Georgia Crisis & Access Line at 1-800-715-4225.

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Consent to Treatment

Patient name

I voluntarily consent to receive behavioral health services from Progressive Consumer Counseling Services (PCCS), including assessment, psychotherapy, family therapy, group therapy, medication consultation when applicable, and any other clinically indicated services.

I understand that no specific outcome can be guaranteed, that I may ask questions about any recommended treatment, and that I may withdraw my consent at any time, in writing, to discontinue services. If I do so, my clinician will offer a safe-discharge plan and any appropriate referrals.

I confirm that the demographic, medical, and clinical information I have provided is true and complete to the best of my knowledge.

Acknowledgment

☐ I have read the full text above, had an opportunity to ask questions, and acknowledge / consent to the terms above.

Patient / authorized representative signature

Printed name Date

If signing for the patient: relationship / authority

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HIPAA Notice of Privacy Practices

Patient name

I have been provided with PCCS's Notice of Privacy Practices, which explains how my Protected Health Information (PHI) is used and disclosed. I understand my rights under HIPAA, including the right to inspect and amend my record, request restrictions on disclosure, and receive an accounting of disclosures.

PCCS may use my PHI to (a) provide treatment, (b) bill for services, (c) operate the practice, (d) comply with applicable law. PCCS will not disclose my PHI for marketing or sell my PHI without my written authorization.

I understand that I can update my preferences for communication and request a new copy of the Notice at any time by contacting our HIPAA privacy officer.

Acknowledgment

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Telehealth Consent

Patient name

I consent to receive services via secure HIPAA-compliant telehealth video. I understand telehealth has the same standard of care as in-person services and that there are limitations: technology may fail, the clinician cannot perform a physical exam, and emergency response may be delayed.

I will be in a private location during my session and will provide my physical address at the start of each session so my clinician can dispatch local emergency services if needed. I agree to provide a valid emergency contact.

AI-assisted scribing or note-drafting may be used during sessions to improve documentation. Any such use will be disclosed and audio is not retained beyond the documentation step.

Acknowledgment

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Financial Responsibility Agreement

Patient name

I understand the published fees for the services I am requesting and agree to pay any copays, deductibles, coinsurance, and self-pay balances. PCCS may charge the payment method on file for these amounts after each session.

I agree to give at least 24 hours notice when canceling or rescheduling. Any cancellation or missed-appointment fee must be disclosed to me in advance and permitted by applicable law and my insurance plan's rules. No such fee will be charged to a Medicaid member where prohibited. I may ask our billing team to explain which policy applies before care.

If I am using insurance, I authorize PCCS to bill my plan and to receive direct payment for covered services. I remain responsible for charges my plan does not cover.

Acknowledgment

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Patient Rights

Patient name

As a behavioral health client in the State of Georgia I have the right to: be treated with dignity and respect; receive culturally competent care; participate in my treatment planning; refuse any recommended treatment; receive a copy of my record; have my privacy protected; and be informed of the risks and benefits of any treatment.

I will not be discriminated against based on race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, veteran status, or source of payment.

I have the right to a written copy of these rights at any time.

Acknowledgment

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Patient / authorized representative signature

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Release of Information

Patient name

I authorize PCCS to share clinically necessary information with my Medicaid/managed care plan, my primary care physician, and other treating providers as needed to coordinate my care. This may include diagnoses, medications, treatment plans, and progress notes.

I may revoke this authorization in writing at any time, except to the extent that PCCS has already acted on it. Authorization expires 12 months from the date below unless revoked sooner.

Acknowledgment

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Coordination of Care

Patient name

I authorize PCCS to coordinate my behavioral health care with my primary care physician, psychiatrist, school (if applicable), case manager, and other treating providers as needed for my care. This may include sharing treatment summaries and care plans.

I understand I can name specific providers I do — or do not — wish my care to be coordinated with by contacting our care coordination team in writing.

Acknowledgment

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Grievance Procedures

Patient name

I have been informed that I may file a grievance about any aspect of my care without fear of retaliation. Grievances may be filed with:

- PCCS Patient Advocate at (404) 209-1209

- Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD) Office of Consumer Relations

- The Georgia Composite Medical Board for licensure complaints

I understand all grievances are reviewed by a clinical leader within 7 business days and that I will receive a written response.

Acknowledgment

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Crisis Safety Plan

Patient name

I agree to help develop a personalized crisis safety plan with my clinician. The crisis plan will include warning signs, internal coping strategies, social contacts, professional supports, and a way to keep my environment safer in the event of a crisis.

In a crisis I will use one of these resources first:

- Call or text 988 (Suicide & Crisis Lifeline)

- Georgia Crisis & Access Line: 1-800-715-4225

- Call 911 for immediate danger

Acknowledgment

☐ I have read the full text above, had an opportunity to ask questions, and acknowledge / consent to the terms above.

Patient / authorized representative signature

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Final Signature & Return Checklist

Patient name

I confirm that the information in this intake packet is true and complete to the best of my knowledge. I have reviewed the consent pages and signed the acknowledgments that reflect my agreement.

Patient / authorized representative signature

Printed name Date

If signing for the patient: relationship / authority

Before returning your packet:

- ☐ Contact information and emergency contact are complete.
- ☐ Applicable primary and secondary insurance information is complete.
- ☐ Medical history and reason for seeking services are complete.
- ☐ I have read every consent page and signed the applicable acknowledgments.
- ☐ I have kept a copy for my records.

Return in person to 6175 Old National Hwy, Suite 420, College Park, GA 30349, or call 404-209-1209 for secure return instructions. Our team will review your packet and contact you about next steps.

This paper option does not change the online intake process. Use the method you prefer.