GENERAL INFORMATION AND PROCEDURES

This form provides information about our counseling relationship, procedures involved and your authorized consent treatment.

Length of Session: 45 to 50 minutes.

Cancellations: Your session time is reserved for you and is taken seriously. ***Except for emergencies, cancellations must be made 24 hours in advance to avoid being charged.***

Fee Structure: ***Client is financially responsible for payment of fees, which will be collected at the time of service.*** The client will also be responsible for any portion of fees not reimbursed or covered by health insurance. Additional cost may be incurred for use of assessment instruments. In the event of an accrued balance, a payment schedule can be negotiated by the client and the therapist.

Confidentiality: Information shared in session is held in strictest confidence according to federal law (Regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony required by a judge, personal danger to self or an identifiable victim); information provided to parents if the client is a minor; and consultation with supervising professionals. Advise may be elicited from professional peers in regard to your case, without revealing your identity.

Client Privacy: Recent laws have been enacted for client privacy. It is important to know that emails and mobile phone conversations are not secure or guaranteed of privacy because they can be potentially intercepted. Therefore, by signing this document you understand that if we have correspondence by email or mobile phone there is a potential for confidentiality to be compromised.

Counseling Approach: The client is held responsible for his/her feelings and behavior while focusing on the "problem" rather than the symptoms. Depending on the therapy issues, various family members may be requested to attend counseling sessions. Although regular attendance will produce the maximum benefits, no therapist can ethically guarantee achievement of goals. The client is encourage to ask questions about the process during the course of therapy, and is free to discontinue therapy at any time. Because of the nature of the counseling process, the client may experience emotional strains, and may possible make life changes which could be distressing.

The signature below confirms that the information has been read and discussed with the therapist, and I _____ accept the policies listed above. I hereby give fully informed consent to therapist, _____ to enter into a psychotherapy relationship with me.

_____ _____

Client Signature Date

Previous Counseling of Psychotherapy

Provider's Name _____

Address _____

Approximate Dates _____

Referred By _____

Please complete the following sentences:

1. I came here today
2. My marriage/relationship
3. Fun for me
4. Growing up in my family
5. If I could change one thing
6. Six months from now

POLICIES

You will be charged for canceled appointments unless notice is received at least **TWENTY-FOUR (24) HOURS** prior to the appointment time so that the time may be scheduled for another client. **Payment is expected at the time of each visit unless prior arrangements have been made.**

I understand and accept the policies concerning both the cancellations of appointments and payment for services. I will be responsible for the agreed-upon payment due of _____ per session.

_____ _____

Client or Responsible Party Date