Center for Mindful Relationships

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CLIENT INFORMATION AND CONSENT FORM

CLIENT INFORMATION _____ TODAY'S DATE: _____

Name _____ D.O.B. _____ Age _____

Address _____ SSN _____

City _____ Zip _____ DL# _____

Home # _____ Cell # _____ Work # _____

Occupation _____

Email _____ **Please star best way to contact you

May I leave a message on your home # Y or N, work # Y or N, cell # Y or N, email Y or N?

PERSON FINANCIALLY RESPONSIBLE:

Are you financially responsible for your sessions? Y or N If NO, please complete this Responsibility portion.

Name _____ D.O.B. _____

Address _____ SSN _____

City _____ Zip _____ DL# _____

Home # _____ Cell # _____ Work # _____

Relationship to client _____

HOW DID YOU FIND ME? (circle all that apply)

Personal Referral Name _____ *May I thank them for the referral? Y or N

Website Psychology Today Google Search Yahoo Search Therapist Unlimited Kudzu

SD Reader MSN Search Craig's List Other _____

If you visited our website, do you have any suggestions for improvement? _____

CONSENT FOR TREATMENT: I agree to participate in therapy with my assigned therapist at CFMR. I accept responsibility for the cost of professional services, including any balance not paid by my insurance company. These charges are to be paid in full at the time of service. I grant to CFMR a lien on my causes of action and on any sums received to the extent of professional fees and costs due CFMR by me.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian (if client is a minor) Date

_____ _____
Therapist Signature Date

"As I believe, so I behave; As I behave, so I become; As I become, so becomes my world." -Unknown

OFFICE POLICIES, PROCEDURES & FINANCIAL AGREEMENT

Welcome! This general information sheet will acquaint you with our office policies affecting issues that frequently arise during the course of therapeutic services. Our primary goal is to offer guidance and insights that will allow you to resolve your personal and interpersonal difficulties. Due to the nature of therapy, it can at times be uncomfortable and challenging. You will be invited to explore debilitating belief systems and introduced to new paradigms and the possibility of change. We will do everything in our professional capacity to be helpful to you. We hope you find your expenditure of time, energy and money worthwhile. If you have any questions about the information below, please discuss with your therapist.

CONFIDENTIALITY

The law, professional ethics and common sense require that whatever you say or do during a therapy session not be shared with anyone without your permission. However, there are exceptions to that rule that we want you to be aware of:

FIRST: Brief written records of each therapy session are kept. These records may be subpoenaed by a court of law under certain circumstances (such as worker's compensation claim for emotional distress).
SECOND: Therapists are mandated reporters. If you share any information about the abuse or neglect of a child, elder person (over age 65), or dependent adult, your therapist is mandated by law to report this information to the appropriate persons.
THIRD: If you indicate that you intend to hurt or kill yourself or someone else, your therapist must act to notify the appropriate persons.
FOURTH: If you are a minor, your parents or guardians have the right to be informed of your progress. We value the safety of the client-therapist relationship, and as such, we can keep them aware of your progress and protect your confidentiality. Your therapist will not share details of your sessions unless there is risk to your health and/ or safety.
FIFTH: If you have insurance that pays part or all of your sessions, be aware that payment requires a diagnosis, and that by signing you are releasing your therapist to put the diagnosis on the insurance form.

_____ **Initial**

FEES

50-minute session is _____ 90-minute session is _____ Group is _____
Conjoint 90-minute session is _____ Psychological Evaluation/Report is _____

All professional time will be billed at a $100/hour rate (prorated at $1.75/minute). This includes report preparation or letters on your behalf for insurance companies or legal matters and phone calls (of more than a ten minute duration). Calls after office hours are charged at 150% of usual rate. Fees are re-evaluated and subject to change every 6 months. Details about the financial aspect of our relationship may be discussed at any time.
For work outside the office, such as seeing clients in the hospital or house calls, the fee is $100 per-hour "portal to portal" -- that is for the time your therapist is out of the office on your behalf.

_____ **Initial**

PAYMENT

Full payment is due at the beginning of each session. Cash, Checks, Visa, and MasterCard are accepted. You can also make a payment via Paypal or through our website. Please let your therapist know if you would like to pay with these options. All returned checks will be assessed a $30 fee.

_____ **Initial**

OUTSTANDING BALANCES

Outstanding balances over 30 days will be assessed a finance charge of 2%, compounded monthly. You will be billed at the first of each month. There is an $8 re-billing fee for every statement sent out after the first billing. There is also a $30 fee for all checks returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts may be turned over to a collections agency. This may impact your credit rating.

If you are seen with a partner for couples counseling, your financial liability extends to your partner's sessions - even if you were not present. This is also relevant in the event of a "no-show."

_____ **Initial**

CANCELLATION POLICY

Your appointment time is reserved for you. If you cannot keep an appointment time please give 24 hours notice so your time can be made available to others who would like to be seen.

If you miss an appointment without notifying your therapist or you cancel with less than 24 hours notice, you will be charged the full fee for the time that was allotted you.

INSURANCE COMPANIES DO NOT REIMBURSE FOR MISSED APPOINTMENTS.

_____ **Initial**

MISCELLANEOUS ITEMS

We do not provide medication. Your therapist will be happy to consult with your family physician regarding the psychological aspects of medication or refer you to a psychiatric colleague if medication evaluation seems appropriate. All decisions regarding medication are to be handled between you and your physician.

If you need to get in contact with your therapist between sessions, you may call or email. If it is not okay for your therapist to email you, please notify your therapist directly. While we can assure privacy on our behalf, due to the nature of the Internet, once the email is sent, we cannot guarantee that outside people do not have access to the information we exchange.

We attempt to be prompt with respect to appointment times and must hold to the designated 50-minute hour in order to be prepared for the next appointment. Many clients find it helpful to arrive in the area a few minutes early to become both mentally and physically prepared to begin their session on time.

Please complete the Client Information/Consent form. Please let us know if you would like a copy of this form to keep for your records.

_____ **Initial**

STATEMENT OF UNDERSTANDING

My therapist has reviewed this client-therapist agreement with me. I understand and agree to all of the above information.

_____	_____
Client Signature	Date
_____	_____
Client Signature	Date
_____	_____
Parent/Legal Guardian (if client is a minor)	Date
_____	_____
Therapist Signature	Date