NEW CLIENT FORM

Welcome! It is our desire that your participation in counseling is a productive and satisfying one. In order to facilitate a therapeutic relationship, we have set forth certain information, which will enable you to make an informed consent to counseling.

Our counselor uses an approach to counseling which takes into account the spiritual, psychological, social, and biological dimensions of the client and strive to establish and maintain a relationship with you, the client, characterized by equality and cooperation that allows you to explore needs, perspectives, and goals. She will seek to offer appropriate suggestions and vehicles to encourage the achievement of your goals.

INFORMATION

Counseling Services and Risks of Counseling

The number of sessions needed depends on many factors and is different for every client. The client understands it is up to the client and the counselor to determine the number and frequency of sessions necessary and that this may change throughout the course of counseling.

It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. Often, growth cannot occur until you experience and confront issues that may cause you to feel sadness, sorrow, anxiety, or pain. The success of your work together with your counselor depends on the quality of the efforts on both parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy. You have the right to refuse or negotiate modification of any technique that concerns you. Possible positive or negative effects of entering or not entering counseling and/or using or not using certain techniques may be discussed at any time during the relationship at the initiation of either you or your counselor. You may bring other family members to a counseling session if you feel it would be helpful or if it is recommended and you agree. However, this must be discussed and agreed upon before the individual joins you in session.

Relationship

Your relationship with your counselor is a professional and therapeutic relationship. In order to preserve this relationship, it is important that your counselor limit other types of relationships with you. Personal and/or business relationships may undermine the effectiveness of the counseling relationship and are unethical. Out of respect for your privacy, your counselor will not initiate conversation with you in a social setting and will be brief if you initiate contact. Also, the counselor will not enter into any non-counseling business or personal relationships with the client or the client's family that could be harmful to the counseling relationship.

Goals, Purposes, and Techniques of Therapy

Our counselors use a variety of techniques and theories in therapy. It is important for you to discuss any questions you may have regarding the treatment recommended by the counselor and to have input into setting the goals of your therapy. We also believe that prayer, Bible study, and the power of the Holy Spirit within an individual are among the resources that can be applied, if the client should choose. If you wish not to have these methods as a part of counseling, please inform your counselor. You and your counselor will discuss goals during the initial session and throughout therapy. As therapy progresses, these goals may change.

Appointments & Cancellations

___ (Initial) Appointments are made by calling 817-479-7019 Monday through Friday during normal business hours. Therapy sessions are approximately 50 minutes in length but may be longer if agreed upon by counselor and client. As a client, you may end the relationship at any point. We request that the termination include one week's notice in writing.

___ (Initial) Cancellations should be received as soon as you are aware that you will miss your scheduled appointment. Due to high demand for counseling services, we request 24 hours' notice for cancellation of an appointment, which makes an appointment possible for someone else. A cancellation fee of $125 will be charged for missed/no show appointments. A late cancel fee of $45 will be charged for appointments cancelled after 8:30am of the same business day. Payment for missed/late appointments will be due at the next scheduled appointment. Cancellations may be made by calling the office at 817-479-7019 or by emailing your counselor.

Therapy Attendance Policy

Therapy services are maximized by regular attendance and home program follow through. Therefore, it is necessary that you attend therapy at least 75% of your scheduled visits. If you are unable to maintain your 75% attendance for 2 consecutive months, you will be discharged from therapy.

From time to time, due to therapist illness or other outside obligation, it is necessary for us to reschedule patients with other available therapists. This can often benefit your child by having a fresh perspective on his/her communication needs and progress.

Parent Attendance

Please plan to attend or be in the building for your child's therapy session. Only patients who are 16 or over are allowed to attend therapy sessions without a parent/caregiver in the building.

Animal Policy

No animals are allowed in the clinic.

Phone Consultations

Phone consultations with clients or parents of minor clients will be free of charge for emergencies or other calls lasting less than 10 minutes in length. If a phone consultation

lasts longer than 10 minutes, it is office policy that we schedule a session in order to discuss the issue. If you wish to continue the conversation more than 10 minutes, you will be charged $20 for up to 20 minutes and the full fee of a session for phone consults lasting longer than 20 minutes. Fee is to be paid to our office at the time of your next session.

E-mail Communication

If you choose, you may contact your counselor by e-mail between sessions. It is important to understand that your counselor may respond, but will be brief. Also, understand that there are risks associated with communicating by email. If at any point throughout the counseling process your counselor believes that you are using e-mail to replace face-to-face counseling or are using e-mail too frequently between sessions, your counselor has the right to set limits on e-mail communication and/or deny your privilege to have further e-mail communication with the counselor.

Payment for Services

___ (Initial) The fee for a counseling session will be $125 per session

All fees are to be paid at the time of service by check, cash, or credit card. If you request, you will be provided with a receipt.

By signing this document, you consent to allowing our office manager, or another appointed staff member, to have knowledge of your identity when paying. They understand the necessity of maintaining strict confidentiality of these records and agree to maintain your records under strict confidentiality guidelines.

No insurance will be filed by your counselor. If you wish to file out of network benefits with your insurance, you will be responsible for filing all documents. In this case, you will be responsible for paying in full at the time the services are rendered. Your counselor will then supply an appropriate receipt at the time of the client's next session. However, no guarantees are made that the client will be reimbursed by their insurance company.

For your convenience, we accept cash, personal checks, MasterCard, Visa, Discover, and American Express.

All returned checks result in a $30.00 NSF fee – which will be applied to your account.

We will make every effort to work with you to make payment arrangements should your bill become outstanding. If all efforts do not bring about a resolution of the account after several attempts, the account balance will be turned over to collects.

Legal Actions & Fees

___ (Initial) I agree to hold my counselor and the counselor's heirs harmless for any alleged or perceived controversies, damages or claims arising out of the rendering of services agreed upon herein. However, in the event that I disregard the terms of this agreement and initiate legal action against my counselor for whatever reason, and my counselor must testify in defense of or otherwise defend self, confidentiality of information revealed to me at any time cannot be assumed. It is understood that my counselor will offer whatever information is deemed appropriate and necessary to defend herself against any legal action initiated by me or as a result of my actions.

___ (Initial) I understand that although the goal of Monkey Mouths is to protect the confidentiality of my records, there may be a time when disclosure of my records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event that disclosure of my records or my counselor's testimony are requested by me or required by law, I will be responsible for and shall pay the costs involved in preparing for and giving testimony. Fees for court appearances or consults with lawyers will be $200 per hour to cover the cost of my counselor's time away from clients and office responsibilities. If the consultation or court appearance takes place off site from the Monkey Mouths' office, the hour will start when my counselor leaves the office and will end upon my counselors return to the office. Such payments are to be made at the time the services are rendered. Monkey Mouths may require a deposit for anticipated court appearances and preparation.

In accordance with state standards, Monkey Mouths will follow the following fee schedule for copies of mental health records. These fees are to be paid by you before the records are released unless there is an emergency situation:

· A basic retrieval and processing fee of $30, which includes the cost of the first 10 pages copied.

· Pages 11 to 400 will be .25 cents per page

· The actual cost of mailing, shipping, or delivering the copies

· No fee will be charged for billing records or the first copy of mental health records that are requested for disability purposes.

Charges for copies for other purposes, such as copies of decrees or other documents that are required to be in the file that I fail to provide a copy of or copies of other documents I wish to be stored in the file, will be charged .25 cents per page, payable documents I wish to be stored in the file, will be charged .25 cents per page, payable at the time the copy is made.

Confidentiality

___ (Initial) I understand that discussions between my counselor and me are confidential. No information will be released without my written consent unless mandated or allowed by law. My counselor is legally required to break confidentiality in the event of child abuse or abuse of the disabled or elderly. Confidentiality will be broken if in my counselor's judgment I become a danger to myself or others**. As necessary, my treatment issues and needs may be shared with the director, office manager and other counseling professionals in a consultation manner for the purpose of supervision and enhancing your progress.** For further information, I can review the Notice of Privacy Practices available online and posted in the Monkey Mouths office. Questions regarding my confidentiality should be brought to the attention of my counselor when we can both discuss this matter further.

By signing this information and consent form, I am giving my consent to the undersigned counselor to share confidential information with all persons mandated by law **as well as our director and office manager**, and I am also releasing and holding harmless the

undersigned counselor from any departure from your right of confidentiality that may result.

In the event that the undersigned counselor reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for my counselor to inform the following person in order to help ensure my safety:

Name _____ Relationship: _____

Phone _____ Client's Initials: _____

This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization shall expire upon the termination of my therapy with the undersigned counselor.

___ (Initial) I acknowledge that I have the right to revoke this authorization in writing at any time to the extent the undersigned counselor has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the copy of that Notice of Privacy Practices of the undersigned counselor that I have received and reviewed. I acknowledge that I have been advised by the undersigned counselor of the potential of the re-disclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule. I further acknowledge that the treatment provided to me by the undersigned counselor was conditioned on my providing authorization.

Right to View Files

___ (Initial) I have the right to copies of my entire file but acknowledge some information may not be in my best interest to review. In the event my counselor, in the exercise of his professional judgment, determines that information in my file may be injurious to me, I waive my right to obtain such potentially injurious information and release my counselor from any and all claims, damages, and causes of action that I suffer or could assert for his refusal to provide me with the information requested. The counselor's discretion shall control.

After-Hours Emergencies

___ (Initial) I acknowledge that if I need to contact my counselor during non-business hours, I can leave a message on the office voicemail (817-479-7019) or send an e-mail with a brief message. My counselor will respond on the next business day unless other arrangements have been made. If I have an emergency which requires immediate action, I will call 911, call the county Crisis/Suicide number at 1-866-672-5100 or go to my local emergency room.

Counselor Incapacity or Death

___ (Initial) I acknowledge that, in the event that the undersigned counselor becomes incapacitated or dies, it will become necessary for another counselor to have access to my files and records. All files generated with regard to my care will be maintained in the counseling offices at Monkey Mouths under the care of the current Director and/or Office Manager of Monkey Mouths. By signing this information and consent form, I give my

consent to allow the current directors and/or office manager to have access to my file and records and provide me with copies upon request or to deliver them to a mental health professional of my choice.

Consent to Treatment

___ (Initial) I voluntarily agree to receive assessment, care, treatment, or services, and authorize the undersigned counselor to provide such care, treatment, or services as are considered necessary and advisable.

___ (Initial) I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned counselor at any time. If I terminate services, I acknowledge that I am free to choose other agencies for treatment and that I may get a list of local referral resources from my counselor. Additionally, based on the judgment of my counselor, I may be referred to a source outside of Monkey Mouths.

___ (Initial) I also understand that my services may be terminated if I become violent, verbally or physically aggressive, or act in a sexually inappropriate way toward other clients, guests, or staff at Monkey Mouths; if I engage in illegal activity on Monkey Mouths property; or if I fail to attend three appointments without an appropriate excuse.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client or Legal Guardian

_____Date_____

As witnessed by:

_____Date_____