Tamora Young, LPC, MAC, Inc. Demographic Information

CLIENT INFORMATION:

First Name: _____Middle Name: _____ Last Name: _____
Address: _____ City: _____State:_____
Zip: _____ County: _____ SS#: _____-____-_____ Date of Birth: _____ Age:_____
Phone #: _____ May we leave a message? ☐Yes ☐No
Other phone #: _____May we leave a message? ☐Yes ☐No
Race: _____ Sex: _____ Marital Status: _____ # of Household members: _____
Employment Status:_____ Work Number: _____ May we call at work: ☐Yes ☐No Work hours: ___
Legal Guardian: _____Phone #:_____
Relationship to Client: _____
Emergency Contact: _____Phone #: _____
Referral Source: _____ Phone #:_____
Name of the Pharmacy you use: _____ _____Phone #: _____
Are you living in the US Lawfully: ☐Yes ☐No Who do you rely on for Social Support: _____
School Attending: _____Grade: _____

****

FINANCIALLY RESPONSIBLE PARTY/INSURED (if other than patient):

Last Name: _____ First Name: _____ Middle Initial: ____ Sex: ___
SS#: _____-____-_____ Date of Birth: _____ Phone #: _____
Address: _____ City: _____ State & Zip: _____
Occupation: _____

****

INSURANCE INFORMATION:

Primary: _____ Policy #: _____ Group: _____
Address: _____ City, State, Zip: _____
Phone Number: _____Secondary: _____ Policy #: _____ Group: _____
Address: _____ City, State, Zip: _____Phone Number: _____

I give my permission for the following people to gain access and have knowledge regarding my (or my child's) treatment with Tamora Young, LPC, MAC, Inc.

_____ _____

_____ _____

_____ _____

****

I authorize the provider of services to release all information necessary to secure payment of benefits to carry out a reasonable level of treatment. I directly assign all medical benefits from my insurance to the provider, if applicable. As a courtesy to you, we may choose to bill your insurance. However, we will allow no more than 60 days for payment. After 60 days, you will be billed for any outstanding balance on your account. All outstanding balances are due 10 days from the statement date. Late fees will be assessed at 10% of the balance. If I have Medicaid as my insurance, I hereby agree that I have been given a freedom of choice of my treatment provider.

Signature of Responsible Party: _____ Date: _____

Revised 3/27/2013

TAMORA YOUNG, LPC, MAC, INC.
A Supportive Hand Throughout All Seasons of Life
4396 Lawrenceville Rd.
Suite 104
Loganville, GA 30052
(678) 313-8784
Fax (770)554-5584

Client Name: _____

INFORMED CONSENT TO TREATMENT

We are pleased that you have selected Tamora Young, LPC, MAC, Inc. (TY, Inc.) to work with you. This letter serves to inform you about the therapeutic treatment process, give you some information and answer questions about the professional relationship between TY, Inc. clinicians and clients. We have a number of client expectations about the professional relationship we embark on with each client.

CONFIDENTIALITY:
Confidentiality is an important part of the mental health/ addictive disease treatment/therapy process. It means that unless you give us written permission, we may not give any information about you to anyone outside of TY, Inc. If you and another adult (someone 18 years of age or older) are seen together, BOTH of you must agree in writing before any information can be released. There are specific times; however, when the law requires us to give information about you with or without your consent:
1. When required by subpoena or court order
2. To report known or suspected instances of abuse, exploitation, or neglect of children and elders.
3. To warn another person that you have threatened his or her life.
4. When you are a danger to your own life.

RISKS and BENEFITS of THERAPY:
While mental health/addictive disease therapy can be an effective mode of treatment for a variety of life problems, positive results can not be guaranteed. One major benefit that can be gained from participating in treatment/therapy includes a better ability to handle or cope with family and other interpersonal relationships. Other benefits relate to the potential to resolve specific concerns brought to treatment/therapy. Seeking to resolve issues between family members and other person can similarly lead to discomfort, frustration and relationship changes not originally intended. TY, Inc. clinicians focus on the relational nature of therapeutic problems. At any time, you may ask your clinician(s) to explain more about how they work, why they are gathering information, or why they are prescribing a particular approach.

PAYMENTS & CANCELLATIONS:
Payment is due at the beginning of each session. We accept cash, personal checks and credit cards. We work with a number of insurance companies via managed care contracts and we are responsible for filing claims for our services; you must pay your insurance copay at the time services are rendered and any remaining balance towards your annual deductible. There are no exceptions. Other insurance plans (out of network) are accepted but you may be required to pay the difference. Payment arrangements are discussed during your initial sessions. We also charge for our time when you require written correspondence.

This is billed according to the amount of time utilized with a minimum fee of $20. This would include correspondence such as letters to other practitioners, disability applications, etc. Insurance will not pay for correspondence. We do not charge customary insurance filing. Telephone consults are also billed at regular rates. The first 5 minutes we consider a professional courtesy to our relationship; thereafter, the time is billed at regular rates to the nearest quarter hour. Returned checks will incur a $35 returned check fee. It is necessary to give your clinician or the TY, Inc. administrative staff at least 24 hours advance notice if you need to cancel or reschedule an appointment. If you give less than 24 hours advance notice, you will be charged a $50 fee, which must be paid before the beginning of your next session. If you miss an appointment without giving any notice at all, you will be charged a $75 fee, which must be paid prior to the beginning of your next session. Insurance will not pay for broken/missed appointments. Failure to show for 3 consecutive session without proper notification will lead to administrative discharge from treatment.

COURT TESTIMONY:
If your involvement in any legal matters leads to any TY, Inc. clinician being subpoenaed to court on your behalf, you will be charged our full clinical fee per hour for the time that the clinician spends preparing to testify, travel to and from court, waiting to appear and testifying. You are responsible for and agree to pay these charges whether or not the clinician ultimately testifies. An initial five hour retainer is required to be paid prior to the court date.

EMERGENCY PROCEDURES:
If you are in a life and death emergency situation dial 911 for assistance or go immediately to your local emergency department. You may also call the Georgia Crisis and Access Line for any mental health emergency 1-800-715-4225. Otherwise, you may attempt to reach your clinician on his or her contact number. If TY, Inc. main office phone number (678)313-8784 and your call will be returned as soon as possible.

Please Read and Sign Below:

- I have read and understand the above statement concerning the limits of confidentiality, the risks and benefits of therapy, payment and cancellation policy, and emergency procedures. I do hereby seek and consent to take part in treatment provided by Tamora Young, LPC, MAC, Inc. I understand that if payment for the services I receive is not made, the clinician may stop treatment. My signature below indicates my informed consent to receive services and reflects that I understand and agree with all of the above statements. I have been given the opportunity to ask questions regarding this information.
- I understand that the fees for services are payable at the time of service and it is my responsibility to pay any deductible amount or co-insurance. I understand that I am financially responsible for all charges whether paid by insurance or not.
- I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel I will be charged $50 for that appointment or if I do not show up, I will be charged $75 for that appointment.
- I acknowledge I have received a copy of Client Rights & Responsibilities, received an orientation of services and aggressive behavior policy.
- I acknowledge I have received the Notice of Policies and Practices to Protect the Privacy of Your Health Information. I acknowledge that I was provided a copy of the "Notice of Tamora Young, LPC, Mac, Inc.'s Policies and Practices to Protect the Privacy of your Health Information" and that I have read (or had the opportunity to read if I so choose again). A staff member of Tamora Young, LPC, Mac, Inc. has reviewed the forms with me and I have received a copy of each form. I have had the opportunity to ask questions regarding these forms/ policies.

Client/Legal Guardian Signature: _____ **Date:** _____

Revised 3/27/2013

Notice of Tamora Young, LPC, MAC, Inc's Policies and Practices to Protect the Privacy of Your Health

Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

• "PHI" refers to information in your health record that could identify you.

• "Treatment, Payment and Health Care Operations"

— Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another Therapist. Another example would be when we release your treatment plan to your insurance company and/or to your primary care physician.

—Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

— Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

• "Use" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• "Disclosure" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about your conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

• Child Abuse — If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.

• Adult and Domestic Abuse — If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authority.

• Health Oversight Activities — If we are the subject of an inquiry by the Georgia Composite Board, we may be required to disclose protected health information regarding you in proceedings before the Board.

• Judicial and Administrative Proceedings—If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

• Serious Threat to Health or Safety — If we determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

• Worker's Compensation — we may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

• *Right to Request Restrictions* —You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

• *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*— You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing therapists. On your request, we will send your bills to another address.)
• *Right to Inspect and Copy* — You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process. Your therapist may also deny access to your Psychotherapy Notes.
• *Right to Amend*—You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
• *Right to an Accounting* — You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
• *Right to a Paper Copy* —You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

• We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
• We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
• If we revise these policies and procedures, we will notify you by mail or on your next session.

V. Complaints

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Tamora Young. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Tamora Young can provide you with the appropriate address upon request.

VI. Cancellation Policy

In the Event of an emergency, you will not be charged for session cancellation. Cancellations for any other reasons that are not received by center staff at least a 24 hours prior to the scheduled session will be billed $50. If you do not show up for your scheduled session and do not call to cancel, you will be billed $75.00. Your insurance company will not pay for missed appointments.

VII. Financial Responsibility

Tamora Young, LPC, MAC, Inc. may choose to assist you in completing and filing any insurance forms, which may be utilized for payments for services; however, you maintain full responsibility for paying all charges for services rendered. You will need to provide all required insurance information when checking in for services and you will need to update any changed insurance information immediately upon the date of change. All co-payments and unsatisfied deductibles are to be paid at the time of services rendered. Tamora Young, LPC, MAC, Inc. does accept payment by cash, check, or credit card.

VIII. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 1st, 2013. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by mail or during your next session.

IX. Patient's Consent

I consent for my therapist to disclose my protected health information (PHI) as required by my insurance company. Furthermore, if my insurance company requires coordination of care with my Primary Care Provider (PCP), I consent for my therapist to disclose my protected health information to my PCP. I have read this statement of Tamora Young, LPC, MAC, Inc.'s practices and policies and I both understand and approve of its content.

_____	_____
Printed Name of Client	Witness
_____	_____
Signature of Client and/or Guardian	Date

TAMORA YOUNG, LPC, MAC, INC.
A Supportive Hand Throughout All Seasons of Life

Primary Care Communication Form

Client Name: _____ Date of Birth:_____

Primary Care Physician: _____

PCP Phone Number: _____ PCP Fax Number: _____

PCP Address: _____

□ I give my permission for my therapist to contact my Primary Care Physician and share protected healthcare information.
□ I do not give permission for my therapist to contact my Primary Care Physician.

_____ _____
Client Signature Date

****

(This section for Therapist Use Only)
Dear Dr. _____,

The above client has received counseling services. I hope the following information will be helpful in coordinating care.

Date of Initial Evaluation: _____

Diagnostic Impression: Axis I: _____ Axis II: _____ Axis II: _____

Other Considerations: _____

Treatment Plan:

Individual Counseling: _____/per month Family Counseling: _____/ per month.

Group Therapy: _____/per month Addiction Program: _____/ per month.

Other: _____

Client Education/ Instructions:
_____

□ I will follow this client until the end of the episode.

□ Please call me at your convenience to discuss this case.

□ Please see attached additional information.

□ Other: _____

_____ _____
Therapist Printed Name Date

_____
Signature

TAMORA YOUNG, LPC, MAC, INC.
A Supportive Hand Throughout All Seasons of Life
4396 Lawrenceville Rd.
Suite 104
Loganville, GA 30052
(678) 313-8784
Fax (770)554-5584

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Client/Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

I hereby authorize Tamora Young, LPC, MAC, Inc. to RELEASE my protected health information (PHI) to:

_____

I hereby authorize Tamora Young, LPC, MAC, Inc. to OBTAIN my protected health information (PHI) from:

_____

Disclosure Scope for PHI Release:

Disclosure may include the following verbal or written information: (check all that apply)

□ Face sheet History & physical
□ Laboratory/diagnostic testing results School information
□ Discharge summary
□ Medication records
□ Behavioral health/psychological consult
□ Psychosocial assessment/Family history
□ ER record report
□ Psychiatric evaluation
□ Substance abuse treatment records
□ HIV/AIDS lab results & treatment history

□ Progress & Case Notes Summary of treatment records & contact dates

□ Psychological evaluation/testing results □ Other:_____

□ Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.

*1. I understand that the information disclosed pursuant to this Authorization **may** be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*

2. I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.

3. I understand that my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and state law, and understand that my authorization will remain in effect for:

□The period necessary to complete all transactions on accounts related to services provided to me.

□ One (1) year

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/custodian of this child.

_____ _____

Signature of Client/Legal Guardian or Legally Authorized Representative *Date*

_____ _____

Witness (Title or Relationship to Individual) *Date*

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

I hereby revoke this authorization, and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me at 4396 Lawrenceville Rd., Suite 104, Loganville, GA 30052

_____ _____

Date this authorization is revoked by Individual Signature of Individual or legally authorized Representative

Safety Plan

Recognize your warning signs & use your coping skills to keep yourself safe!

Triggers & Stressors

(Behaviors, Situations and Circumstances that are triggers for you)

_____

_____

_____

_____

Warning Signs

(Your behavior signals that show you're growing more and more at risk)

_____

_____

_____

_____

Things to do……

My Goals for My Behavior:

1.

2.

3.

4.

5.

People I can call…

*

*

*

*

I, _____ do not have access to prescription medications for use other than as prescribed or access to weapons, lethal medications and/or other My Coping Skills… means of self-harm.

What I can do to be calm RIGHT NOW: _____

What can my support person do to help me?

Client Signature: _____ Date: _____

Supportive Person Signature: ____ _____ Date: _____

CRISIS PLAN

Name: _____ Date:_____ Address: _____

City, State: Zip: _____ Phone #: _____Alternative #: _____

DOB: _____Gender: M/F Parent/Guardian: _____

SUPPORT PEOPLE*: Those you want called in case of a crisis (family, advocates, support):*

Name _____Relationship _____ Phone _____

Name _____Relationship _____ Phone _____

Name _____Relationship _____ Phone _____

M**EDICAL INFORMATION:**

Primary Care Physician: Name _____ Phone _____

Physician prescribing current medications: Name _____ Phone _____

Person who has a ***current*** list of your medications: _____

Medications that have been helpful in emergencies, explain: _____

Medications to avoid, explain: _____

Allergies /adverse medical effects: _____

Mental health concerns: _____

Substance use concerns: _____

Medical concerns: _____

CRISIS INFORMATION:

Describe what crisis looks and feels like to you When you've been in a crisis situation, what kinds of support did you seek? What (people, places, services) things were the most helpful?

Explain:_____

_____

Early signs that I'm not feeling well: _____

What I can do to help myself: _____

Ways that others can help me: _____

What I don't want/What doesn't help: _____

I know I need to get help when: _____

In a crisis I need to know I have help with: ☐Pets ☐Children ☐Transportation ☐Other:

Explain: _____

Numbers to Call in times of Crisis:
Tamora Young, LPC, MAC, Inc. (678) 313-8784

Therapist: _____ Phone: _____

Client Name: _____ Signature: _____ Date:_____

Parent / Legal Guardian (if applicable): _____ Date:_____

Staff Name: Signature: _____ Date:_____

If this is a life threatening medical emergency, please call

COUNSELING INTAKE FORM

Name_____Age_____Date_____

Full Address_____

_____

Home Phone_____Work_____E-mail_____

Physical History (please be accurate, medical records may need to be disclosed at some point)

General Health_____

Are you now under a doctor's care?_____If yes, name of doctor_____

Reason for doctor's care_____

Are you taking any medication?_____If yes, what kind?_____

Reason for medication_____Last medical examination_____

Have you ever been hospitalized for a physical illness?____Describe_____

_____

Have you ever been hospitalized for a mental illness?____Describe_____

_____

Any recent major illnesses or surgeries?_____

Any recurrent or chronic conditions?_____

Do you smoke:_____Do you take drugs?_____If yes, what kind?_____

Do you drink?_____How much?_____

Any Previous Therapy/Counseling?_____If yes, describe, when, where, how long, what for_____

_____

What do you hope to achieve with therapy?_____

_____

Work History

Occupation_____ How long?_____

If presently unemployed, describe the situation_____

_____

Hobbies/Avocations_____

Family Systems Information

Where born_____How long there_____Ethnic ID_____

Parents: Father alive_____Where residing_____Relationship_____

Mother alive_____Where residing_____Relationship_____

Marital Status_____#of marriages_____Spouse's name_____

Living with a partner_____How long_____Partner's Name_____

Children:#1 M F Age_____ #2 M F Age_____ #3 M F Age_____#4 M F Age_____#5 M F Age_____

Siblings: Circle your place in the family. If a sibling is deceased, put an X through the placement number.

#1 M F Age____ #2 M F Age____ #3M F Age____ #4 M F Age____ #5 M F Age____ #6 M F Age_____

Family Alcoholism or Domestic Violence?_____ Sexual Addictions or Abuse?_____

Parents divorced?_____If yes, what year_____Your age at the time_____

If deceased, what year?_____Your age at the time_____Cause of death_____

Any step-parents?_____If yes, describe when and your relationship with them_____

_____

If reared by someone other than your birth parents, describe the situation in some detail_____

_____

Tell anything else in the space below that you think would be helpful for me, as your therapist, to know.

Spiritual History

Religious upbringing_____Present Affiliation_____

Is this an important part of your life_____Whywhy not_____

Emotional Status

Are you currently experiencing strong emotions? ____If yes, describe_____

_____

Do you make decisions based on your emotions?_____How well does that work for you?_____

_____

Did you have what you would consider to be childhood or other traumas?_____If yes, describe_____

_____

Have you been treated for emotional disturbances?_____If yes, when?_____

Have you had any thoughts of suicide____If so, when_____Do you have any thoughts now_____

Present Situation

Please state why you decided to come for counseling/therapy_____

What is the nature of your situation_____

_____

What would you like to experience that is different from what you are experiencing now_____

_____

How long has this been a problem for you_____

_____

Please state what you would like to work on in therapy_____

_____

Personal Agreements

I understand that I may be asked to do certain "homework exercises" such as reading, praying, changing behaviors, and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.

I further understand that much of the work done will be to resolve issues and will depend on my honesty, and willingness to do the things I need to do to move forward even if it is painful and difficult.

I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent unless I am violating codes of abuse, harm to myself or others.

I understand that I will pay $50.00 for appointments not canceled with 24 hours notice and I will pay $75.00 for a no-show appointment.

_____ (client signature and date)

As your therapist/counselor, you honor me by sharing your life and growth with me. I will not hide myself behind silence or position and will have high regard for you as a person. I will bring the best that I know from my study and experience. I will bring you the highest of my insight, wisdom, and spiritual guidance.

I will keep a holistic perspective in our work together because I believe that the Physical, Spiritual, and Soul (mind, will, emotions) all work together to form the wholly healthy person.

You can expect truth from me even when you may not want to hear it. I will always have compassion and empathy for you in all that we do. I value you as a person in need of care. I will do my best to honor that.

_____ _____

Therapist Signature Date