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Registration Form

Client 1:

Name: _____ Date: _____

Date of birth: _____ Current age: _____

Address: _____

Cell phone: _____ Email: _____

Place of Employment: _____ Occupation: _____

Emergency Contact (name/phone): _____

Primary care physician (optional):_____ phone: _____

Referred by: _____

Permission to text for scheduling purposes: Yes ___ No ___

Permission to leave a detailed voicemail: Yes ___ No ___

Client 2:

Name: _____ Date: _____

Date of birth: _____ Current age: _____

Address: _____

Cell phone: _____ Email: _____

Place of Employment: _____ Occupation: _____

Emergency Contact (name/phone): _____

Primary care physician (optional):_____ phone: _____

Referred by: _____

Permission to text for scheduling purposes: Yes ___ No ___

Permission to leave a detailed voicemail: Yes ___ No ___

Other Household members

Name M/F Relationship DOB Age

1) _____

2) _____

3) _____

4) _____

5) _____

Cancellations/Fees

A 24-hour notice is required for cancellations and rescheduling. Otherwise, normal session fee will be charged for the missed appointment.

Session Fee is not covered by insurance and I will not provide any documentation to be provided to your insurance company. By signing below you are acknowledging and agreeing to this policy.

Fees

$150 per hour

_____ _____

Client 1 signature Client 2 signature

Authorization to treat

I give my consent to my therapist to provide assessment and therapeutic services to me and or my child within the scope of her license. I understand that my therapist will work with me to achieve progress towards reducing my problems as quickly as possible, but resolution is not guaranteed. I understand that my therapist will talk with me about our progress, but that it is ultimately my responsibility to end therapy if I feel it is not helpful. I agree to cooperate with my therapist in the treatment process to carry out therapeutic homework assignments and to follow through with any medical treatment as prescribed by my physician. I further agreed to keep my scheduled appointments and understand that failure to do so more than two times may result in my care being terminated. By signing below I agreed to payment and arrangements set forth, affirm that all my questions have been satisfactorily answered, and I give informed consent for my treatment.

_____ _____

Client signature Date Client signature Date

Professional Disclosure (HIPAA) / Confidentiality

Your signature below indicates you have received the notice of privacy practices and agree to and understand the limits of confidentiality.

_____ _____

Client signature Client signature

Waiver of Medical/Psychiatric Consultation

I understand that under the provisions of KSA 65-6404 (b) (3) my therapist is required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that she may have observed while working with me. In the event that I do not have a primary care physician or psychiatrist I acknowledge that my therapist has recommended that I seek medical consultation. By signing below I am indicating that I waive my right to such consultation and that I am aware that this waiver will become part of my clinical record.

_____ _____

Client signature Date

_____ _____

Client signature Date

Telehealth Consent

I hereby consent to engage in telehealth with my therapist. I understand that telehealth is a mode of delivering healthcare services including psychotherapy via communication technologies over Internet or phone to facilitate diagnosis, consultation, treatment, education, care management and self management of a patient's healthcare. By signing this form I understand and agree to the following: I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect my confidentiality of my treatment information during in person therapy. The same mandatory and permissive exceptions to confidentiality outlined in the informed consent I received from my therapist also apply to telehealth services. I understand that there are security risks associated with participating in telehealth including but not limited to, the possibility of my treatment information being accessed by unauthorized individuals. I understand that miscommunications between myself and my

therapist may occur via Telehealth. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions. I understand that in some instances telehealth may not be as effective or provide the same results as in person therapy. I understand that while telehealth has been found to be effective in treating a wide range of emotional issues there's no guarantee that telehealth is effective for all individuals. I understand that some telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other parties' written permission.

_____
Client signature / Date

_____
Client signature / Date

Client Rights

You have the right:

1) To be treated with consideration and respect.
2) To expect quality services provided by concerned and competent staff.
3) To a clear statement of purposes, goals, techniques, rules of procedure and limitations as well as potential dangers of the service to be performed plus all other information related to or likely to affect the ongoing counseling relationship.
4) To obtain information about the case record and to have the information explained clearly and directly.
5) To full acknowledgement and responsible participation in the ongoing treatment plan.
6) To expect confidentiality and that no information, (with exceptions for safety, intent to harm others, abuse/neglect of a minor, or elder abuse/neglect) will be released without written consent.
7) To refuse any recommendation of services.

Security of Records

Your treatment of record related and related financial records are kept in a locked file cabinet your records may also be digital and kept in a locked and secured laptop records will not be made available to others without signed authorization to release information and payment for the records prior to releasing them.

Information regarding psychotherapy:

1) Psychotherapy may involve remembering unpleasant events and can arouse intense emotions of fear and anger; feelings of anxiety, depression, frustration, loneliness and helplessness may be experienced. Also feelings of relief, energy, power, self acceptance, and well-being may also occur.
2) Psychotherapy is not always effective and may, in some cases; result in deterioration rather than improvement of a client's psychological functioning. Psychotherapy has been shown effective in about 75% of cases.
3) There are numerous forms of psychotherapy, which vary, not only in terms of underlying theory and methods employed, but also in terms of time commitment and cost. We will attempt to provide treatment that is realistic in both areas.
4) Current research has failed to demonstrate that any one form of psychotherapy is necessarily more effective than any other.
5) Depending upon a client's condition, there may be available alternatives to psychotherapy, such as medications or behavior modification; I will make these recommendations if they are appropriate, based upon my assessment.

_____
Client signature / Date

_____
Client signature / Date