COUNSELING CENTER *for* SEXUAL HEALTH

CLIENT INFORMATION FORM

Client's Name _____

Address_____

_____

Home Phone _____

Mobile Phone_____

Other Phone (if applicable) _____

Fax Number (if applicable) _____

Email Address (if applicable) _____

Date of Birth_____

Spouse's Name (if applicable) _____

Children's Names & Ages (if applicable) _____

_____ _____

_____ _____

Referred By_____

Primary Care Physician_____

Previous Therapist (if applicable)_____

Revised 08/28/19

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POLICIES AND CONSENT FOR TREATMENT

APPOINTMENTS: Appointments are usually scheduled for 45-50 minutes. Clients generally are seen weekly or more/less frequently as acuity dictates and you and I agree. You may discontinue treatment at any time, but please discuss any decision to do so with me. I request at least two weeks advanced notice so that together we can effectively plan for continued care.

PAYMENT AND BILLING: Payment for services is an important part of any professional relationship. ***Full payment is expected at the time of each appointment*** unless otherwise arranged. Cash, Checks, Visa, MasterCard, Discover, and American Express are each acceptable forms of payment. Checks should be payable to **"Counseling Center for Sexual Health, Inc."** Upon request, monthly statements can be provided containing all pertinent data necessary for insurance purposes should the client choose to seek reimbursement. Any additional information required by an insurance company will be provided at no additional cost. Fees are reviewed and modified annually. Clients are notified of any change in fee 30 days prior to it taking effect. My fee schedule is as follows:

Individual Therapy	
(45 -50 minute session):	**$200.00**
(90 minute session):	**$275.00**
Couples or Family Therapy	
(45 -50 minute session):	**$250.00**
(90 minute session):	**$375.00**
Group Therapy	
(90 minute session):	**$75.00**
Phone Consultation	
(15 minute increments, prorated for time needed):	**$55.00**
Other Services as described below	
(30 minute increments, prorated for time needed):	**$115.00**

***Telephone consultation*:** Telephone consultation may be suitable or even necessary at times during the course of therapy. It involves professional services rendered with regard to your therapy, case planning, crisis management, and/or the imparting of information pertaining to your case. It includes telephone conferences with other professionals or individuals (which you have authorized) such as physicians, lawyers, school counselors, and the like. Routine calls requiring 10 minutes or less will not be billed. Of course, there is no charge for calls regarding appointment scheduling or similar business.

***Reports and Correspondence*:** There is no charge for time spent making simple reports to insurance companies. However, if a lengthy or complex report or correspondence becomes necessary, it will be billed at the "Other Services" rate for the amount of time required. This is not an item covered by most insurance policies.

***Other Services*:** In-person consultation and/or collaboration with other professionals (which you have authorized), hospital visits, depositions, court appearances, and other in-person services are billed at the "Other Services" rate for the amount of time required. If travel is required beyond one-half hour from the office, a fee for travel time is assessed also. Some of these ancillary services may require payment in advance.

Returned Checks and/or Failure to Pay: If at any point during the course of our work together you are unable to pay for your therapy, please discuss this with me right away so that we can address this before it becomes an issue that could compromise your treatment. There is a $20.00 fee for each check returned from the bank for insufficient funds. If your account with me is unpaid and we have not arranged a payment plan, a collection agency or small claims court may be utilized, and you will be responsible for reasonable collection fees. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due to me.

CONFIDENTIALITY: All communication between therapist and client is strictly confidential unless: (1) The client signs a release of information form or otherwise authorizes the release in writing. (2) The therapist is ordered by a court to release or disclose information. (3) The client presents a physical danger to self or others. (4) Child and/or elder abuse or neglect is suspected. In the latter two cases, the law mandates disclosure of information to potential victims and/or legal authorities so that protective measures may be taken. (5) The client states they are intentionally accessing or downloading child pornography. The law mandates therapists to report this information to the authorities.
Because I work within a group practice, consultation may occur with professionals within this practice. In addition, administrative assistants from my office may access billing and scheduling information.
Please refer to the "What You Should Know About Confidentiality in Therapy" form for additional details on the limits of confidentiality in therapy. Also discuss any specific questions or concerns you have about this directly with me.

TREATMENT OF MINORS AS INDIVIDUAL CLIENTS: When a client who is a minor is in individual therapy, the parent or legal guardian has the right to ask for information about the minor's therapy, and the therapist, acting in the best interest of the minor, has the right to limit the amount of information disclosed. Please discuss any specific questions or concerns you may have about this directly with me.

AVAILABILITY: I am typically not immediately available by telephone. My telephone is answered by voice mail which I check frequently during regular business hours, which are Monday through Friday, 9:00 AM to 6:00 PM. Although I will make every effort to return your call personally on the same day you make it, calls regarding non-clinical matters may be returned by my office staff. Messages left on weekends and holidays will typically be returned on the following business day. If you have not heard back from me within 24 business hours, please call me again. If you communicate with me via email, please understand the risks associated with using email, such as: email can be intercepted, altered, forwarded or used without authorization or detection, email can be used as evidence in court, email may not be secure and the confidentiality of such communication may be breached by a third party. If you cannot reach me, and you feel that you cannot wait for me to return your call, you should call 911. If you are feeling suicidal or a family member is threatening violence or suicide, you need to call 911 or head to the nearest Emergency Room immediately. If I am unavailable for an extended time, I will provide you with the name of a trusted colleague whom you can contact if necessary.

CANCELLATION: If you need to cancel an appointment, please do so **at least 24 hours in advance**. Otherwise, you will be billed for the missed appointment at the regular rate.

PATIENT LITIGATION

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's legal matter. Therapist will generally not provide records or testimony
unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of $150.00.

TERMINATION OF THERAPY

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

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"No Secrets" Policy for Family Therapy and Couple Therapy

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit- that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel is necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual's interest may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____ (couple/family or other unit) being seen, acknowledge by our individual initials below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with our therapist, and that we enter couple/family therapist in agreement with this policy.

Each family member must initial:

Initials _____ Initials _____ Initials _____ Initials _____

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CONSENT TO TREATMENT

By initialing each line and signing below, you are stating that:

_____ I give my permission and consent to Darilyn Shano, M.S., LMFT to provide psychotherapeutic treatment to me and/or _____, who is/are my spouse/child/children.

_____ I understand that Darilyn Shano, M.S., LMFT is not providing an emergency service, and I have been informed of whom to call upon in an emergency or during weekend and evening hours.

_____ I understand, under no circumstance, may I record (via audio or video) my therapy sessions with Darilyn Shano, M.S., LMFT. I furthermore understand, any unauthorized recording will result in termination effective immediately.

_____ I understand the Notice of Privacy Practices; acknowledge they are located in the office and have access to a full copy on the website, www.counselingcenterforsexualhealth.com.

_____ I have read and understand the above explanations regarding the limits of confidentiality.

_____ I have read and understand the above explanations regarding billing and payment policies, and I understand that I will be charged for any sessions not cancelled at least 24 hours prior to the time of the scheduled appointment.

_____ While, I expect benefits from this treatment, I fully understand that because of factors beyond our control, such benefits and particular outcomes cannot be guaranteed.

_____ I have had the opportunity to discuss all of the aspects of treatment fully, have had my questions answered, and understand the treatment planned. Therefore, I agree to comply with treatment and authorize Darilyn Shano, M.S., MFTI to administer the treatment(s) to me and/or my child.

Client name(s) (printed) _____

Client/Parent/Guardian Signature:_____ Date_____

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AUTHORIZATION FOR RELEASE OF CLIENT/PATIENT INFORMATION

I, hereby authorize the exchange of information between ***Darilyn Shano M.S., LMFT*** and

_____ regarding _____ .

I give my permission to share the following information:

____ Educational ____ Medical

____ Social ____ Psychological

____ Psychiatric ____ Other: _____

I understand this authorization is valid for one year from the date listed below. I also understand this information may not be released to any other person or organizations without my permission in writing. A photocopy of this authorization shall be considered valid.

Signature: _____ Date: _____

Printed Name: _____

Relationship to client (i.e. self, mother, guardian, etc.): _____

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Credit Card Authorization Form

In addition to cash and checks, we accept American Express, Mastercard, Discover, and Visa as forms of payment for services rendered. Please complete this form if you prefer to pay with your credit card. Services are normally billed during the same week as the provided session. On occasion (holidays, etc.) there may be a delay of up to one week after the session before your card will actually be charged.

Upon your request, we will provide you with a detailed billing statement/receipt at the end of each month.

Card Type

____American Express

____Mastercard

____Visa

____Discover

Card Number

_____

Expiration Date: _____

Security Code (3 or 4 digits): _____

Name as it appears on card _____

Address

(where credit card bills are sent) _____

_____

_____

I authorize *Counseling Center for Sexual Health* to bill the credit card noted above for psychotherapy services rendered.

Authorized Signature _____

Printed Name _____

Date _____