NEW CLIENT REGISTRATION FORM

High Expectations Counseling

Please complete the information requested based on the person/s who will be receiving counseling:

The client is a: (please circle) **Adult** **Child/Adolescent** **Couple** **Family**

Date: _____

Please circle the form of services you are interested in: **Skype In office Session Phone Email Residential (Please fill out the information as it relates to the clients that will be involved in the therapeutic process. (family, couples, adolescents)**

Clients First Name _____Last Name_____Email _____

Clients First Name _____Last Name_____Email_____

Home Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone:_____ Sex: _____ Age:_____

D.O.B: _____ Email Address: _____

Referred By: _____

Person to contact in case of emergency: _____ Phone: _____

Employer: _____Phone: _____

Please list below any relevant information pertaining to: past therapist, helpful resources that you want part of therapy. Also provide the **best method of communicating** for appointment reminders, and confidentiality purposes.

_____

_____

_____

Informed Consent for Therapy Services

CLIENT SERVICE AGREEMENT

Welcome to HEC (High Expectations Counseling). This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. It is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them prior to services rendered. For all types including those in office, residential, out of state, and online services, the intake packet, **must contain a credit card on file that is confidential**. **This ensures that the space has been reserved for cancellations.**

THERAPEUTIC SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of Therapy often requires discussing the unpleasant aspects of your life. However, Therapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Therapy requires a **very active effort on your part**. In order to be most successful, **you will have to work on things we discuss outside of sessions.**

The first session will involve a comprehensive evaluation of your needs. By the end of the first session, I will be able to offer you some initial impressions of how our work will be most beneficial and include collaboratively how we will approach therapy. It is important that you make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them immediately.. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments run an average of 60 to 90 minutes in duration, once per week or at a frequency we agree on. Some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with a **24 hour notice**. If you miss a session without cancelling, **my policy is to collect a no show payment of $120 for 90 minute sessions and $80 for 60 minute sessions.** (Unless we both agree that you were unable to attend due to circumstances beyond your control.) I will assist to schedule another time for the appointment. In addition, you are responsible for coming to your session on time. I do not prorate for the extra time as most therapist. You will pay an agreed upon flat rate for session.

PROFESSIONAL RECORDS

I will keep appropriate records of the therapeutic services that I provide. Your records are maintained in a secure and locked location in the office. I keep brief records noting that you were in session, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discuss, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. You also have the right to request that a copy of your file be made available to any other health care provider at your written request. Please allow 30 days to receive request.0

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement is essential at important times throughout treatment. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern. It is my goal to work with the entire family and keep all involved and updated on progress.

CONTACTING OUTSIDE OF BUSINESS HOURS

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. I will however try my best to get back to you within the end of the business day. At these times, you may leave a message on my confidential voicemail. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please go to your Local Hospital Emergency Room, call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences. You may also reach me via email at sally@highexpectationscounseling.com or text at 407-967-1327

CONSENT TO THERAPY Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to these terms.

_____ _____

Signature of Client Date

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Mental Health Practitioner Date

PROFESSIONAL FEES AND INSURANCE POLICY

FEES

In Office Session 90 minutes $150

In Office Session 60 minutes $100

Online Face to Face Sessions 60 minutes $80

Telephone Sessions 30 min-60 min $40 (30 min)
$80 (60 min)

Please initial if we have agreed upon a different price: Price: _____ Initial _____

Between Session I may text you videos and helpful resources that I recommend you watch. These are just recommendations. There is no fee for you should you have questions via text throughout the week. Any checks returned to the office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, consultations which you have requested, or the time required to perform any other service which may be requested of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality.

If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify. Court appearance cost starts at $250 per hour.

I am not an in network provider for insurance plans. I will supply you with a receipt of payment for services, an itemized invoice with all clinical diagnostic requirements which you can submit to your insurance company for third party reimbursement.

_____ _____
Signature of Client Date

_____ _____
Signature of Client Date

_____ _____
Signature of Therapist Date

CREDIT CARD ON FILE

Information to be completed by the Cardholder:

The undersigned agrees and authorizes High Expectations Counseling (Sally High. LMHC) to charge the credit card indicated below for any account balances which include, but are not limited to fees for no show appointments and phone calls between sessions. A receipt will go to your preferred email address upon completion of therapy services for your records.

-Please note that the time slot is saved for you and without 24 hour notice of cancellation, a **$100** dollar fee will be charged for missed session.

_____ (initial)

Preferred email address for receipt; _____

Type of Credit Card: MasterCard Visa Discover American Express other: _____

Card Number: # _____ -_____-_____-_____ -

Expiration Date: _____ (month/year)

Security Code: _____ (last 3 numbers on back of card)

I, _____ authorize High Expectations Counseling LLC to process the above credit card as "Signature on File" for any balance due on my account. I understand this authorization will expire upon conclusion of care. This information is stored and unable to be accessed by anyone but myself.

_____ _____

Cardholder's Signature Date

_____ _____

Signature of Mental Health Practitioner Date