Client Intake & Consent to Therapy

Basic Information

Client Name: ____

Mailing Address: ____

Date of Birth: _____________ **Gender:** Male Female

Social Security Number: ___________________________

Type of Counseling Interested In:

Pre-Marital Counseling

Individual Counseling

Couples Counseling

Family Counseling

Spiritual Counsel

Contact Information

Phone Number: ____________________________

Email: ___________________________________

Preferred Method of Contact (By selecting text or email you are consenting to the communication of medical information over electronic mediums that are not considered to be confidential) Text Phone Email

Consent for Treatment

THERAPISTS INFORMATION DISCLOSURE STATEMENT

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in counseling, you have certain rights that are important for you to know about because this is your therapy, and our goal is your well-being. There are also certain limitations to those rights that you should be aware of. As therapists, we have corresponding responsibilities to you.

FEES FOR SERVICE

Our fee per session is as follows:

- Pre-Marital counseling (45 min): $50 per session, or $210 paid in advance for 6 sessions
- Individual counseling (50 min): $100 per session
- Couples counseling (90 min): $160, initial session is $200 for a 2 hrs session
- Family Counseling (60 min): $100 per session
- Spiritual Counsel (45 min): $85 per session

If we decide to meet for a longer session, we will bill you prorated on the hourly fee. Telephone calls or emails up to 5 minutes are provided at no charge, but will accrue an additional prorated charge of the hourly rate.

We are not willing to have clients carry a balance. Major credit cards are accepted.

Overdue bills will be charged 1% per month (12% per annum) interest.

If you refuse to pay your outstanding balance we reserve the right to provide your name and the amount due to a collection agency.

Full Fee will be charged for not appearing at your scheduled appointment time or failing to notify at least 24 hours in advance of a cancellation.

I understand the above statement. ___________ (Initials)

CRISIS INFORMATION

Growing Hope Counseling does not provide crisis intervention. Instead, we give crisis information to our clients at the beginning of treatment. In the event of a crisis, please call the Crisis Hotline Idaho at 208-788-3596 (208-578- 4114 bilingual), Idaho Suicide Prevention Hotline at 800-273-8255, or dial 911.

QUESTIONS OR COMPLAINTS

If you are unhappy with what is happening in therapy, we hope you will discuss it with us so that we can respond to your concerns. We will take such criticism seriously, and with care and respect. If you believe that we have been unwilling to listen and respond, or that we have behaved unethically, you can complain about our behavior to the Examining Board for Counseling, Boise, ID. You are also free to discuss your complaints about us with anyone you wish, and do not have any responsibility to maintain confidentiality

about what we do that you do not like, since you are the person who has the right to decide what you want kept confidential.

CLIENT CONSENT TO PSYCHOTHERAPY

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the identified fee of the applicable counseling service received, unless otherwise adjusted in writing. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Bruce Pagano II, LPC. I understand that I can terminate therapy at any time I wish and that I can refuse any requests or suggestions made by the therapist. I am over the age of 14.

BY SIGNING I AM ACCEPTING AND CONSENTING TO PSYCHOTHERAPY AND ALL THE ABOVE-IDENTIFIED TERMS.

____ ____________

Signature **Date**