Family Services and Resource Center, Inc. Disclosure

Thank you for choosing Family Services Resource Center, Inc. (FSRC) for your counseling and/or coaching services. The following disclosure is designed to give you information about your time as a client at FSRC. All of the staff at FSRC are committed to your success. We believe that sharing our policies and procedures with you at intake will help you get the most from your experience at FSRC. In keeping with this approach, we have listed various office policies below. Please read through these, ask any questions you may have, and sign where directed before or during your initial appointment.

Thank you for allowing us to serve you!

CONTACT INFORMATION

You may call (904) 214-3222 regarding any questions or concerns. After hours, leave a voice mail message with your contact information and you will be contacted the next business day. FSRC is not a 24-hour counseling center. In an emergency, please call 911 on go to the nearest emergency room. You may also e-mail info@fsrcenter.com or your individual therapist, however this information is subject to the technology disclosure below.

The therapists and coaches at FSRC have been trained in a variety of methods and will determine which approaches and techniques would most benefit you. During your initial screening, a review of your current needs will be conducted and recommended services will be discussed with you. Your therapist or coach will be able to discuss the average length of service for situations that are similar to yours. You have the right to ask and to know about the techniques and approach of your therapist or coach, and you are also entitled to a second opinion. Please ask your therapist or coach if you would like this information. You may also terminate therapy or coaching at any time without penalty, as participation in therapy or coaching is voluntary.

In a professional relationship (such as a therapist and client, or coach and client), sexual intimacy between a therapist and/or coach and client is ***never*** appropriate! If such intimacy occurs, it should be immediately reported in writing to the Department of Health 4052 Bald Cypress Way, Bin C75, Tallahassee, Florida 32399.

**GOALS OF COUNSELING**

There can be many goals for the counseling relationship. Some of these will be long term goals such as improving the quality of your life or learning to live with mindfulness and self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior or decreasing/ending drug use. Whatever the goals for counseling, they will be set by the clients according to what they want to work on in counseling. The counselor may make suggestions on how to reach that goal but you decide where you want to go.

**RISKS/BENEFITS OF COUNSELING**

Counseling is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling 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.

However, there are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

**CONFIDENTIALITY**

Generally speaking, the information provided by and to a client during therapy and or coaching sessions is confidential. If the information is confidential, the therapist or coach cannot be forced to disclose the information without the client's consent. FSRC therapists, coaches, and office personnel will not inform others that you are in therapy or coaching and the content of sessions/meetings will remain confidential. The only time this confidentiality may be broken is if one or more of the following exceptions/conditions apply:

* If you pose physical danger to yourself or others
* If you disclose that you or another person has physically or sexually abused a child, an incompetent or a disabled person, or an elderly person.
* If you disclose that a child, an incompetent or a disabled person, or an elderly person is suffering due to neglect.

If any of the above are disclosed in session, we are mandated by law to report such information to the appropriate State agency.

Additionally, it is important to know and understand that your information may be shared with other FSRC therapists, coaches, and/or administrators for the purposes of case consultation, supervision, billing, and other administrative functions. ***By your signature below you authorize and release your therapist and/or coach to provide this information to FSRC as a whole***.

It is possible that you and your therapist or coach may run into each other in a public place. Should this occur, the therapist or coach must protect confidentiality by not acknowledging you unless you first acknowledge your therapist or coach. If you approach your therapist or coach, contact should be brief and no session material should be discussed so confidentiality can be maintained.

**TECHNOLOGY**

***By your signature below, you authorize FSRC to contact you by phone and/or text using the number you provide at intake or by e-mail with the address provided.*** If this is not a safe number or e-mail account to leave messages at, please let your counselor know in writing or note this on the intake packet itself. Your therapist or coach may call you using a VOIP (internet based voice over IP phone) or a cell phone both of which may not be completely confidential because of potential technology issues.

**PAYMENT**

FSRC has an agency fee schedule and cancellation policy, which will be provided to you at intake. By signing this document below, ***you attest that you have received this fee schedule and cancellation policy and agree to the payment requirements.***

FSRC Counseling only accepts cash or credit card payments at this time. Self-pay clients must make full payment at the time of service. Clients wishing to have FSRC bill their insurance company for services rendered must pay their co-pay at the time of service. Please make checks payable to Family Services and Resource Center, Inc. There is a $30 returned check fee for any check that we are unable to process due to insufficient funds.

All payments are due at the time of service unless prior arrangements have been made.

**SESSIONS**

Sessions are normally from 45 - 60 minutes in length though this may vary based on your individual treatment plan with your therapist or coach.

Please arrive promptly for sessions. Sessions will end at the designated time regardless of when it was started. Therapists are only required to wait 15 minutes past the scheduled time for an appointment before a no-show will be billed.

**CANCELLATIONS**

We understand that you may need to cancel an appointment. It is helpful for us to know if you will not be coming, so we ask that you give us 24 hours notice for any change or cancellation. Any late cancellation (less than 24 hours notice), change, or missed appointment will be charged according to the FSRC Cancellation Policy.

**AGREEMENT**

I understand that, consistent with the HIPAA requirements, consent to treatment and consent to release will expire after twelve months and I may revoke such consent at will, although revocation is not retroactive**.**

I have been informed of and read the preceding information and agree to it. I authorize treatment and/or coaching of the person named below and agree to pay all fees for services rendered by my therapist or coach.

If you have any questions or would like additional information, please feel free to ask.

**ATTESTING THAT I HAVE RECEIVED AND UNDERSTAND THE FSRC PATIENT DISCLOSURE STATEMENTS, I HAVE RECEIVED A COPY OF THE HIPAA PRIVACY PRACTICES, AND I CONSENT TREATMENT THROUGH THERAPY OR COACHING UNDER THE ABOVE LIST OF DISCLOSURES I HAVE SIGNED BELOW:**

CLIENT

SIGNATURE DATE

SIGNATURE OF SPOUSE IF

FAMILY/MARITAL COUNSELING DATE

SIGNATURE OF PARENT OR

GUARDIAN IF CLIENT IS A MINOR DATE

THERAPIST/COACH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_

INTAKE FORM

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_ Gender:\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Residence:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_County of Residence:\_\_\_\_\_\_\_\_\_\_

Is Client the Responsible Party? (circle) yes no

Name of Responsible Party (if different than client):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Responsible Party Billing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: (circle) Single Married Widow(er) Cohabitating Divorced Re-Married Other

Name of Spouse or Partner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse or Partner’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Method of Contact for Appointment Reminders or Therapist Contact:

\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_ Text \_\_\_\_\_\_\_\_ E-mail

Names of Children DOB Living in the Home?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PLEASE COMPLETE THIS PAGE IF CLIENT IS UNDER 18

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_ SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Address (If different than client):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_ SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Address (If different than client):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Relationship: (circle) Married Divorced Separated Widow(er) Never Married

Client’s Legal Guardian(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provide contact information here if not listed elsewhere on form:

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If parents are not together or child is currently in foster care or adopted, who has the right to make medical decisions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide therapist with custody and other legal paperwork needed to ensure therapist has permission by guardians to see client. Without necessary paperwork, therapist may be unable to see the client.

PAYMENT AGREEMENT/FEE SCHEDULE

***(Initial each line item and sign below)***

\_\_\_\_\_\_\_\_\_\_\_\_ Payment is due at the time of your appointment. Cash, check, and credit card are acceptable forms of payment.

\_\_\_\_\_\_\_\_\_\_\_ The standard fee for services is $90 per 50-60 minute individual, couples, or family counseling or coaching session (on the phone or in the office)

\_\_\_\_\_\_\_\_\_\_\_ Co-payments are determined by your insurance carrier. Co-payments are due in full at the time of session.

\_\_\_\_\_\_\_\_\_\_\_ A fee of $30 will be assessed for a returned check and future payments must be made in cash.

\_\_\_\_\_\_\_\_\_\_\_ Cancellations require 24 hours notice prior to the time of the appointment. You will be charged the full agreed upon fee,

 contained in the Cancellation Policy, for cancelling appointments with less than 24 hours notice or for missing appointments without prior notice.

\_\_\_\_\_\_\_\_\_\_\_ I understand that it is my responsibility to keep a valid credit card on file for co-payments, no-show fees, and cancellation fees. I acknowledge, that should I fail to keep a valid credit card on file for these costs, that I will be responsible for all legal fees associated with collection on my account and an additional $30 collection fee.

\_\_\_\_\_\_\_\_\_\_\_\_ Phone calls in excess of 15 minutes will be billed to the client’s account in accordance with the standard session fee.

\_\_\_\_\_\_\_\_\_\_\_\_ Treatment may be interrupted or terminated; after 2 unpaid no shows, due to 2 consecutive cancellations, or after unresolved debt of 2 or more sessions.

By initialing each line item above and by signing below, I acknowledge that I understand and commit to the above Payment Agreement and enter into the agreement willingly and voluntarily.

Client Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Therapist and/or Coach: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CANCELLATION POLICY

**Sessions must be cancelled at least 24 hours in advance in order to avoid a cancellation or no show fee.**

The fees are as follows:

1. If you do not attend an appointment and fail to notify that the scheduled appointment cannot be kept (no show) you will be charged $90 for the missed session.
2. If you cancel your appointment with less than 24 hours notice, there will be a $45 charge for the missed session. However, emergencies do occur, and the fee will be reduced to a $25 charge if the appointment is cancelled for one of the following reasons:
	1. You cancel because of work or school obligations.
	2. You cancel because of personal illness or illness with a family member.
	3. You cancel because of unexpected transportation problems.
3. There is a limit of 2 exceptions for emergencies (as listed in section 2) per calendar year. After 2 exceptions to the cancellation policy for late cancellations, you will be charged the full late cancellation fee of $45.

**Your insurance will not pay for no shows or late cancellations. This fee is your personal responsibility.**

If you find yourself running late for your session, please call as soon as you are aware of the delay. Without notification that you will be late, your appointment will no longer be available after 15 minutes and you will be billed for a missed session (no show fee).

**You are required to keep a valid credit card on file. Your card will be charged in the event of a no show fee or late cancellation fee as appropriate.**

**CREDIT CARD AUTHORIZATION**

* Being the cardholder, by signing below, I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize Family Services and Resource Center, Inc. (FSRC) to charge my credit card for clinical services provided, for services not cancelled within 24 hours, no show fees, and any additional charges associated with my account as stated in the Payment Agreement/Fee Schedule.
* Family Services and Resource Center, Inc. (FSRC) will provide me with a weekly or monthly invoice detailing dates of services and applicable fees and will include receipts for those fees.
* I further agree that in the event my credit card becomes invalid, I will provide FSRC with a new, valid credit card upon request to be charged for the payment of any outstanding balance.
* I understand that if I fail to maintain a valid credit card, on file, for charges to my account, that I will be responsible for any legal fees associated with collection and an additional $30 collection fee on balances over 30 days past due.
* Charge authorization may be withdrawn at any time, but only by written request.

Signature of Client and/or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Complete the Following:

Name of Cardholder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code (3-4 digit code on the back of the card):\_\_\_\_\_\_\_\_\_\_\_ Billing Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FACILITY POLICIES**

Initial on the line provided for each statement. **(*If*** *client is a minor both Client and Guardian initial and sign.*)

1. \_\_\_\_\_ I understand that I am responsible for my children’s behavior (if client is a minor). I agree not to leave children unattended at this facility for any reason. I understand that supervision for children is not provided before, after, or during my therapy or coaching session. I agree to pick up my children immediately after their session.

2. \_\_\_\_\_ I understand while in therapy or coaching sessions, I will not be allowed to harm myself, others, or any property. If I become a threat of harm to any of these, the authorities will be notified immediately and I will be held responsible for any damages incurred.

3. \_\_\_\_\_ I am aware that FSRC is not responsible for any items left in the therapy/coaching room during or after sessions.

4. \_\_\_\_\_ I understand that my therapist or coach is being supervised by a licensed professional and that session material may be discussed in the context of supervision, training, and consultation.

5. \_\_\_\_\_ I agree to give FSRC permission to correspond with me by letter, telephone, or by other means necessary to check on my progress after discharge.

8. \_\_\_\_\_ I understand that recommendations for nutrition, supplements, exercise, and other healthcare suggestions are not intended to replace medical advice and treatment from your primary care physician.

9. \_\_\_\_\_ I understand that occasionally FSRC sends newsletters and other information to clients and other interested parties unless otherwise personally directed/requested in writing.

10. \_\_\_\_\_I/We have willingly placed my/ourselves in the program of FSRC and do authorize to act in my best interests and to perform any treatment and/or coaching that is deemed proper and fit.

11. \_\_\_\_\_By means of my/our signature, I/we hereby release FSRC, its staff and directors from all suit, libel, damages or legal litigation of any kind that could be brought against them for any reason by us on our behalf.

12.\_\_\_\_\_I understand that FSRC will not get involved in any legal proceedings of any kind including but not limited to custody disputes and divorce proceedings.

13. \_\_\_\_\_I/We do also hereby state that this agreement and contract is to be in effect for the life of my/ourselves and that even after death this contract shall stay in effect.

**I attest that I have read, reviewed, understood and agreed to abide by all of the above-initialed policies, disclosures, and acknowledgements:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Client name (PRINT) Guardian Name (PRINT)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Client Signature of Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Therapist and/or Coach Date

Please check all that apply to you and may be a focus of treatment:

* Anxiety
* Depression
* Relationships and Boundary Issues
* Lying/Manipulation
* Academic Problems (Children and Adolescents)
* Behavioral Problems (Children and Adolescents)
* Marital Concerns
* Dealing with Divorce
* Parenting Concerns
* Risk of harming yourself or others
* Anger Issues
* Developmental Problems
* Sleep Problems
* Confidence/Self-Esteem Issues
* Feeling Isolated From Others
* Afraid or Suspicious
* Losing Track of Time
* Nightmares
* Intrusive Memories
* Sexual Issues
* Stress Management
* Traumatic Experiences
* Sexual Abuse
* Physical Abuse (Including Domestic Violence)
* Emotional/Mental Abuse
* Loss of Control
* Destructive Life Patterns
* Substance Abuse (Past and/or Present)
* Family of Origin Issues
* Career Changes
* Financial Problems
* Specific Fears or Panic
* Memory Problems
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BRIEF SURVEY

What brings you in to therapy today?

Where did you hear about FSRC Counseling?

What are you hoping for in your therapy experience?

What are your concerns about therapy?

Have you ever been in therapy before?

If yes, was your experience positive or negative and why?