Collaborative Counseling, LLC

Client Registration

Client Name:____
First name Last name

Address:____
Street City State Zip Code

Date of birth:_________/_________/_________ Age:_____________ Gender:_________________________

Best Phone #:__________________________________ Can messages be left: YES__________NO_________

Can text messages be received on this number: YES_____________________NO_________________________

Email address:____ Can emails be sent: YES_______NO_______

Additional contact information:____

Parent/Guardian (If client is a minor): ____

If student- Name of school:____ Grade:________________

Contact number for parent/guardian:____

Emergency contact name:________________________________ Relationship:__________________________

Emergency contact phone number:____

How were you referred to Collaborative Counseling?____

Have you received counseling in the past?____

Are you currently taking any medications? If so, please list medications and dosages:_____________________

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ALL INFORMATION PROVIDED IS CONFIDENTIAL AND PRIVILEGED FOR PROFESSIONAL USE ONLY

Consent to Treatment

I hereby authorize Collaborative Counseling, LLC to administer mental health treatment. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand that Collaborative Counseling, LLC may be obligated to release information due to legal limitations of confidentiality or if required by the court of law.

For minors: I, as the parent/guardian, represent and warrant that all information submitted is true and correct. I warrant that I have complete and proper authority to involve the above referenced minor client for treatment at Collaborative Counseling, LLC.

Client/Guardian Initial:________

Policies and Procedures

Collaborative Counseling, LLC maintains the highest of professional and ethical standards. Please review the following policies and procedures. If you have any questions or concerns regarding any aspect of the policies and procedures, please feel free to discuss this with your therapist.

Confidentiality: Confidentiality is of utmost importance in a therapeutic relationship. Collaborative Counseling, LLC ensures that all information given by you or your family is treated as confidential and may be released only upon your written consent or as required by law.

The legal limitations of confidentiality include: suspected or reported child or elder abuse/neglect, suspected or reported situations in which your therapist believes you to be potentially life threatening to yourself or others, or if required by the court of law to provide information.

Emergency Services: Collaborative Counseling, LLC does not provide 24-hour emergency coverage. Should you have a potentially suicidal/homicidal situation, please call 911 IMMEDIATELY or go directly to the nearest hospital based on the severity of your situation. You may also contact the Mobile Crisis Team 24 hours a day/7 days a week if you are experiencing a clinical emergency at 561-383-5777. If you are in need of community resources, you may call 211.

Court Testimony: Collaborative Counseling, LLC believes that in some cases, it can be disadvantageous for the client's therapist to testify in court on their behalf. Involvement in court cases will be decided on a case-by-case basis. All forensic work (testimony, court reports, correspondence, etc.) will be billed at the rate of 200% of our therapy fee.

Sessions: Please respect that Collaborative Counseling, LLC schedules sessions for 60 minutes. Your session will be limited to the original scheduled time. Should your therapist be responsible for the session starting late, you will receive your entitled session time. Sessions are scheduled with your therapist.

Client/Guardian Initial:________

Billing and Payment Information

Collaborative Counseling, LLC will collect payment at the time and date of each service. Payments are accepted in the forms of cash, check, or credit card. There will be a $25 charge for any returned checks.

Cancelled/Missed Appointments: Appointments must be cancelled within 24 hours of your scheduled appointment time. Collaborative Counseling, LLC designates valuable time for each client and that time cannot be used for others when appointments are missed or cancelled without notice. In the case of a missed appointment, or a cancellation with less than 24 hours notice, the client will be responsible to pay for the appointment fee.

Collaborative Counseling, LLC will collect a _$125_ payment at the time of each service.

I understand I am responsible for payment of my scheduled session if I do not provide 24 hours notice for a cancellation. **Client/Guardian Initial:________**

HIPAA Notice

I acknowledge receipt of HIPAA Notice of Privacy Practices, Office Policies, and information regarding the agreement for psychotherapy services. This signature page will be placed in your medical chart. Should you have any questions, please address them with your therapist.

I hereby acknowledge by signing below that I accept the above-explained Consent to Treatment, Policies and Procedures, Billing and Payment Information, and HIPAA Privacy Practices.

____

Signature of Client/Guardian **Date**

____

Name of Client **Date**

____

Therapist Signature **Date**