Center for Christian Therapy

CLIENT INFORMATION FORM

Full Name _____ Today's Date _____

Birth date_____ Address_____

City_____ State_____ Zip_____ Sex: M F Marital Status: M S D Sep

Phone _____Spouse phone_____

Email Address_____Spouse email (if in couples counseling)_____

Responsible Party Information if client is a child

Full Name_____ Relationship to Client _____Birth date_____

Cell phone _____ Email address_____

Sex: M F Marital Status M S D Separated Employer_____

Referral Source
Who Referred You?_____

Presenting Problem
Reason for seeking therapy? _____

What do you hope to gain from therapy? _____

Medical History
Primary Care Physician _____

Please list any health concerns_____

Please list medications _____

Therapy History
Have you received therapy before? Name _____When_____How long_____

Have you ever seen a psychiatrist? Name _____

Are you currently seeing a psychiatrist? Name _____

Are you currently taking psychotropic medication? Please list _____

Emergency Contact

Name_____Relationship to Client _____

Phone_____

Informed Consent
I have received a copy of, understand, & agree to the Service Agreement.
I consent to psychotherapy treatment with Center for Christian Therapy.

Signature _____ Date _____

Center for Christian Therapy

Professional Service Agreement

Thank you for coming to us for therapy. We look forward to working with you to improve your life and your relationships. This agreement is to clarify the business aspects of our relationship, and to help our therapeutic relationship go smoothly.

Fees & Billing

- Therapy Sessions: Fee for a 50-minute therapy session is $110. Payment is due at the beginning of each session by cash or check. Credit card payment is also available through PayPal, ask for details. Brief phone calls are included in the fee.
- Couples and Family Sessions: 60 minute sessions are $125
- Phone Sessions: If you would like work on things with your therapist between sessions, we will try to be available to support you. We charge for $35 for 20 minutes sessions.

Health Insurance Coverage

We prioritize our clinical work with our clients, therefore we do not bill insurances directly. You will be asked to pay out of pocket, but if you have an out of network mental health benefit, you can submit a form to them that you will receive monthly over email. Your insurance company will reimburse you for any covered costs.

Confidentiality

- The information you share with me will be kept confidential. I will ask you to *sign a release-of-information* form before I discuss your treatment, or send my records about you to anyone else.
- If you are involved in a divorce or other court proceedings, please do not sign a release form with your lawyer or custody evaluator. We want to offer you the best possible therapy and to do that we need to create a safe place for you to talk. Talking with a lawyer conflicts with that goal.
- Your confidentiality/privacy is protected by state law and by the rules of my profession, except in the following circumstances. The limits of confidentiality are:

1. If you were sent to me by a court or an employer for evaluation or treatment, the court or employer expects a report from me. You have a right to tell me only what you are comfortable with telling.
2. If you make a serious threat to harm yourself or another person, the law requires me to try to protect you or that other person.
3. If I believe a child, or a dependent adult, has been or will be abused or neglected, I am legally required to report this to the authorities.
4. If you send a health insurance claim form to your insurance for reimbursement, it will have a mental health diagnosis listed and it will become part of your permanent medical record.
5. In order to provide you with the best treatment, I may consult with other mental health professionals about your case.

Text/Email/Skype

You may want to contact us via email or text or Skype. We are committed to take precautions to protect your privacy, however, we must advise you that we do not use an encrypted email/phone system and there is a risk of your confidentiality being compromised when using this kind of technology. If you would like to use text or email or Skype to communicate, please sign that you understand this risk, but you would like to use it anyway.

_____

Signature

Cancellation Policy

If you are unable to make your scheduled appointment, please cancel at least 24 hrs. in advance. If notice is not given, I am still committed to working for you during the hour and you will be billed for the full session fee.

Assessment We try hard to match you with a therapist that is a good fit for you from the beginning, but there are occasions where we realize something in the first few sessions that precipitates the need for a referral.

Emergency Situation

If you or a family member have an emotional or behavioral crisis call the University of Utah Neuropsychiatric Institute at 801-583-2500, or call 911, or go to the nearest emergency room.

I understand, and agree to, the policies as stated above, and I give consent for treatment with Center for Christian Therapy.

Client's Name		Date
Client's (or Responsible Party's) Signature	Relationship to Client	Date