NEW CLIENTS-YOUR FIRST APPOINTMENT

TIME OUT COUNSELING

Thank you for choosing *Time Out Counseling*. Prior to your **first appointment, NEW CLIENTS** are asked to read, print, and complete the following forms, providing information/signature as required. By completing these forms ahead of time, this will allow us more time to use the first session getting to know one another. Please remember to bring them to your first appointment or they will have to be completed at the office prior to us beginning our first session together. If you have any questions please feel free to call us!

New Client Information and Verification Form	This form provides new client information and indicates acceptance of treatment.
Psychosocial Assessment	A very comprehensive form that addresses all aspects of personal and family history as they relate to physical and mental health.
Cancellation Policy Acceptance Form	By signing this form you acknowledge and accept our appointment cancellation policy.
Financial Policy	By signing this form you acknowledge and accept our financial policy.
Authorization to Release or Obtain Information	By signing this form you authorize your counselor to either obtain relevant information from or release information to another person, facility as appropriate.

810 Anchor Rode Drive
Naples, FL. 34103
239-590-7502
timeoutcounseling070@gmail.com

New Client Registration Form

TIME OUT COUNSELING

Thank you for choosing *Time Out Counseling*. Please complete the form below.

Questions please feel free to ask!!

Name: _____ Date: _____

D.O.B. _____ SS#: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Tel#: _____ Mobile Tel#: _____

Can we text you? _____ Can we leave a message? _____

Email address: _____ Can we email you? _____

Emergency Contact: _____ Tel#: _____

Referred by: _____ Tel#: _____

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New Client Information and Verification Form

Welcome! Thank you for choosing *Time Out Counseling*. Below you will find information regarding therapy expectations and policies. Your counselor will be happy to answer any questions you may have regarding this information.

Client/Counselor Relationship:

You and your counselor have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of bartering.

Risks and Benefits:

Counseling and psychotherapy are beneficial but as with any treatment there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, development of healthy coping strategies and specific problem solving. These benefits cannot be guaranteed. It is the counselor's desire however, to work with you to attain your personal goals for counseling and/or psychotherapy.

It is your responsibility to **provide necessary information to facilitate effective treatment**. You are expected to play an active role in your treatment, including working with your counselor to outline your treatment goals and assess your progress, completing questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do in between sessions than on what happens in the session.

The counselor's goal is to provide the **most effective therapeutic experience** available to you. If at any time you feel that we are not a good fit, please discuss this matter with your counselor so we can determine if transferring to a more suitable counselor right for you.

Appointments:

Appointments are usually scheduled on a **weekly or bi-weekly basis and are for 50 minutes**. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by you and your counselor. Please be mindful that your scheduled time is **reserved especially for you.** If you have very specific times you need to come in or if you are only able to come in during times of high demand, it is important to schedule your appointments in advance. We will try to accommodate you as best we can.

Cancellation Policy:

If you need to cancel or change your appointment, please email or call our office at: 239-590-7502 a**t least 24 hours in advance.** This will free your appointment time for another client. A **credit/debit card number will be taken at the time of appointment scheduling and will be charged in the event of a missed appointment unless 24 hours' notice is given or other arrangements have been discussed.** The fee is **$30.00 for a late cancellation** or missed appointment. If two sessions in a row are cancelled with less than 24 hours' notice, your counselor may request to speak with you before continuing to reschedule appointments.

Professional Fees:

Our fees at *Time Out Counseling* are $65.00 for 50 minute individual or couples therapy sessions
$30.00 Late Cancellation or No show fee
$40.00 returned check fee

If you become involved in any court or legal proceedings that require my participation, you will be expected to pay for all of the therapist's professional time, including preparation and transportation costs, even if I am called by another party. The fee is $175.00 per hour for preparation, communication, travel and attendance at any legal proceeding. A three hour minimum payment of $525.00 is due in advance for our time.

****We accept cash, checks, or PayPal for payment.**

Emergencies:

You may encounter a personal emergency that will require prompt attention. If this happens, please contact your **local Crisis Center, hospital or 911.** Every attempt will be made to schedule you as soon as possible after you

receive emergency services or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, attempts will be made to return calls in a timely manner. When out of town travel is planned, your counselor will make reasonable attempts to inform you of this absence and develop a plan with you to be used during this absence. Please use telephone communications for emergencies, not text or email.

Limits of Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are **limits to the privilege of confidentiality**. These situations include: 1) **suspected abuse or neglect of a child, elderly person or a disabled person**; 2) **when your counselor believes you are in danger of harming yourself or another person, or you are unable to care for yourself;** 3) **in natural disasters whereby protected records may become exposed,** or 4) **when otherwise required by law.** You may be asked to sign a ***Release of Information*** so that your counselor may speak with other mental health professionals or to family members about issues discussed. A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without **your written consent**, unless in those situations as outlined in the Limits of Confidentiality section above. Medical records are **locked and kept on site**.

In order to give you the most complete and helpful care, your counselor may consult with other professionals in the field. Supervision sessions with other professionals may occur to ensure the counselor is practicing ethically and competently. In this case, the counselor may discuss details of your case however specific identifying information will not be provided and confidentiality will be maintained between the counselor and the other professionals involved.

If you are participating in a group, couples, or family counseling, reasonable attempts to ensure confidentiality will be taken but **absolute confidentiality cannot be guaranteed**. Please note that if you ***send your counselor a text message or email that it is not secure, your confidentiality*** cannot be guaranteed. **Please use telephone communications for emergencies not text or email.**

Social Media Policy:

In accordance with the ethics of the counseling profession, the counselor or staff at *Time Out Counseling* LLC, **does not accept** friend or contact requests from current or former clients ***on Facebook*** or other social media sites. Doing so has the potential to compromise your confidentiality and our respective privacy. The counselor will not write professional endorsements for clients due to the potential for violating the ethical code on dual relationships. *Time Out Counseling*, LLC does have a company Facebook page where we post counseling related information that you are welcome to follow. Some counselors may also have a LinkedIn account where professional information is posted.

Consent for Treatment:

By signing this client information and consent form as the client or guardian of said client, **I acknowledge that I have read all three pages**, understand and agree to the terms and conditions contained in this form in its entirety. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving a mental health assessment, treatment and services for me (or my child if said child is the client) and I understand that I may stop such treatment or services at any time. By signing below, you are stating that you have read the above and understand the policy statement and that you have had your questions answered to your satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Name of Client (please print) _____

Signature: _____ **Date:** _____

Counselor/Witness: _____

Date: _____

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FINANCIAL POLICY

TIME OUT COUNSELING

Thank you for choosing *Time Out Counseling* for your professional services. The following is our financial policy, **which we require you read, agree to and sign prior to any treatment**. This policy is strictly enforced with all patients.

Payment Terms Full payment is **due at time services are rendered**. We accept as payment: •Visa• MasterCard • Cash/Check • PayPal

Please read and initial the following:

_____ I understand that *Time Out Counseling* does not accept private insurance as payment at this time. **I am responsible for payment** of services rendered.

_____ I authorize *Time Out Counseling* Associates to release pertinent information concerning my care to my insurance company if needed.

_____ I authorize the release of information to any agency necessary for payment on my account.

Court Terms: There is a $525.00 minimum fee that needs to be paid in advance if this counselor is requested to be an expert witness in court for any matter involving the client. This covers travel and preparation. Every hour thereafter is charged at a rate of $175.00.

Returned Checks: If a check is returned unpaid or non-sufficient funds, there will be a $30.00 returned check fee. Fees may be recovered using electronic debit through your financial institution. Checks will no longer be accepted once a check is returned unpaid or non-sufficient funds.

Collection Terms: Any account past due 60 days will be turned over to a collection agency. All applicable collection fees will be the patient's full responsibility. Fees for collection are equal to 50% of the past due amount.

Cancellation/Missed Appointments: As a courtesy, we require a 24 hour cancellation notice prior to the scheduled appointment. Individual appointments not canceled within 24 hours will be charged a fee of $30.00 which must be paid prior to next appointment.

Acknowledgement: Your signature below acknowledges you have read, understood, and agree to the terms of our FINANCIAL POLICY.

Signature: _____ Date: _____

Print Name: _____

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CANCELLATION POLICY

If you fail to **cancel a scheduled appointment without 24 hours'** notice, we can't use that time for another client and you will be billed for your missed appointment, **this is your responsibility.**

You will be automatically charged a fee of **$30.00** for missed appointments or cancellations less than a **24 hour notice.**

**This fee will need to be paid prior to scheduling another appointment.

Remember the time of your appointment is reserved especially for you. Please be mindful of your counselor and our time as well.

Thank you for your consideration regarding this matter.

_____

Client signature

_____

Date

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Authorization to Release or Obtain Information

TIME OUT COUNSELING

CLIENT NAME _____ DATE OF BIRTH_____

This will authorize_____ (NAME OF Counselor) to

release to and/or obtain information from: _____

_____

(NAME OF INDIVIDUAL, HOSPITAL, OR AGENCY WHO WILL RECEIVE/RELEASE INFORMATION)_____

(ADDRESS) _____(PHONE NUMBER, E-MAIL)_____

Information to be released includes (**Please INITIAL each item to be released):**

_____ ALL INFORMATION including medical, psychiatric, psychological, HIV/AIDS, alcohol, drug or other substances.

_____ Specific information/reports, such as: (Please INITIAL each item to be released)

_____ Treatment/Discharge summary ____ Physical/laboratory results _____Clinical/psychiatric/psychological assess.

_____ Verbal exchange of information. Please specify: _____

_____ Other: _____

Specific purpose for disclosure of information:_____

This information has been disclosed from records whose confidentiality is protected by Florida Statutes and federal regulations governing confidentiality (42 CFR Part 2). This information cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time (except to the extent that action has been taken) by written notification to the counselor named above. If I DO NOT revoke this authorization, it will expire automatically in 365 days.

_____ _____

Client Signature Date

_____ _____

Signature of witness Date

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