



Client Name _____

Client Information and Acknowledgement

The counseling program at The Parenting Center is designed to help people with personal or family problems. It is our goal to decrease emotional distress so that clients can achieve a more positive level of functioning and experience a greater sense of well-being. The Parenting Center attempts to do this through play therapy, individual, family, couple and group counseling in the shortest amount of time possible. The therapist may recommend the client attend an education class in combination with counseling or make referrals for additional services at The Parenting Center or other agencies.

Confidentiality

I understand that the information disclosed in counseling is confidential. However, my counselor may discuss my case with his/her supervisor for consultation. Only the counselor and select staff have access to my file. Information will not be released to any other source without my written consent. I understand that the exceptions to confidentiality occur when:

- 1) there is any suspicion or disclosure of possible child abuse, abuse of the elderly or handicapped
- 2) there is a probability of imminent physical injury to self or others
- 3) the client is a child and a parent, guardian or managing / possessory conservator has a right to the information
- 4) a judge orders the release of records
- 5) insurance, managed care companies, individuals, corporations, or governmental agencies involved in paying or collecting fees for mental health services that require information for processing payment or collection.
- 6) therapy notes are not routinely released; a chronological narrative summary is released, if requested
- 7) when an allegation of negligence is made by a client regarding a therapist

(initial)

Financial Agreement:

I have been informed that I will pay a fee of \$ _____ for each 50 minute counseling session.

(initial)

I understand I will be charged up to \$90.00 for any appointments I do not cancel at least 24 hours in advance.

(initial)

I also agree to pay for any of the therapist's time spent in court or consultation at the rate of \$100 per hour.

(initial)

I further agree to pay in full for sessions not reimbursed by Medicaid, CHIP, Child Protective Services, or other third-party payer.

(initial)

I understand that if I request a copy of my records, a fee will be charged.

(initial)

Termination of Services

I understand that if I fail to come for my appointments on a consistent basis my counseling services will be terminated by the therapist.

(initial)

I understand that if I fail to show for two consecutive appointments, my time slot will no longer be reserved and I must call the scheduling office for a new appointment.

(initial)

Other

I understand that if I have any grievance regarding my counseling I should contact the Clinical Supervisor or Director of Programs at The Parenting Center.

(initial)

I also authorize my therapist to contact medical or law enforcement personnel if the therapist reasonably suspects I may do serious harm to another or myself.

(initial)

I understand that after normal working hours I will follow the directions indicated on The Parenting Center answering machine or call 911.

(initial)

Client / Parent / Guardian Signature

Date

The Parenting Center Representative

Date

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