205 N. 5th St., Suite 203

St. Charles, MO 63301

636-328-9700

**Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_M \_\_F

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_Social Security number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ok to leave message at home? Yes No Ok to leave message at cell? Yes No

Please indicate phone preference: Home Cell

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate any restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship status: \_\_ Single \_\_\_Married \_\_Divorced \_\_Remarried \_\_Widowed \_\_\_Domestic Partner \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will your partner be attending conjoint counseling sessions? \_\_ Yes \_\_No

**Employment**

Currently employed: \_\_ Yes \_\_ No

Current employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral:** Who may I thank for referring you to this office?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_

Is it okay to send a thank you letter? \_\_ Yes \_\_ No

**What brings you in today?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any children Yes  No Do they reside in your home? Yes  No

Who lives at home with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any family members you wish to have involved in treatment and why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you been in counseling before? Yes No If Yes, Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was accomplished? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you ever been hospitalized for psychiatric or substance abuse services Yes No

If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any support groups you attended in the past or presently: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes No If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to quit? Yes No

Is drug or alcohol use an area of concern: Yes No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list all current prescriptions, regularly taken - over the counter meds and supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Conditions (Check all that apply)**

Allergies Anorexia Asthma

Broken Bones Communicable Diseases Diabetes

Fainting/Dizziness Hearing Problems Heart Disease

High/Low Blood Pressure High/Low Blood Sugar Liver Disease

Major Injuries OB/GYN Problems Obesity

Seizures/Epilepsy Stomach or Intestinal Problems Thyroid Problems

Ulcer Vision Problems

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever experienced?**

 Depressed mood  Rapid shifts in mood  Rapid Speech

 Anxiety/Panic Attacks  Phobias  Sleep Disturbances

 Hallucinations  Unexplained losses of time  Memory lapses

 Alcohol/Substance Abuse  Frequent Body Complaints  Eating Disorder

 Body Image Problems  Thoughts of harming yourself Physical abuse

 Family Conflict  Parenting Issues  Work Difficulties

Sexual Abuse Intimate Partner Violence  Marital Difficulties

 Suicide Attempt  Thoughts of harming someone else

 Repetitive Thoughts (e.g. Obsessions)

 Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)

Have you experienced or witnessed a life threatening event? Yes No; If yes, explain: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you consider to be your strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you like most about yourself? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Information**

1. Emergency contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Emergency contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Information and Agreement Form for Insurance Clients**

We truly appreciate your choosing to come to us for counseling services. As part of providing high-quality services, we need to be clear about our financial arrangements.

* If you have health insurance, it may pay for a part of the cost of your treatment here. To find out if this is so, we need the information requested below. I am currently an In Network provider for Anthem Blue Cross and Blue Shield, Cigna Behavioral Health, United Health Care, and HealthLink.
* If you do not participate in one of the above listed plans, I am considered an Out of Network Provider. I can provide you with a receipt of your payment and you can submit this to your insurance provider for reimbursement. How much you are reimbursed is between you and your insurance provider.
* If you do not have insurance or chose not to use your insurance, the charges for your sessions are $100 per hour. The undersigned therapist will look to you for full payment of your account, and you will be responsible for payment of all charges. Cash and check are preferred forms of payment.

\_\_\_ It is our policy to keep a credit card on file to use for late cancellations or past due fees. Your credit card will be swiped at your first appointment and kept electronically with the HIPPA compliant service Jitzuzu. With the exception of missed appointments or late cancellation, I will discuss any other charges with you in advance.

\_\_\_ Direct telephone contact with the therapist over 5 minutes will be billed on a prorated basis at the above rates ($25 for 15 minutes, $50 for 30 minutes, etc.)

\_\_\_ Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist’s normal hourly rate for the time involved in preparing for and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the therapist.

**Insurance Information**

Policy holder’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address of employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_

Commercial health insurance carrier/company:

Name of company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # sessions allotted: \_\_\_\_\_\_\_\_\_\_ Co-pay: \_\_\_\_\_\_\_

Claims address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment of benefits**

• I hereby authorize the release of any medical information necessary to process my insurance claim to my third party carrier.

• I authorize the release of any medical information to my referral source.

• I understand that when I elect to use my health insurance benefits to pay for psychotherapy services that my diagnosis, symptoms and substance abuse (if any) issues and history will become part of my permanent insurance records. My insurance company has retained the right to access and copy any and all of my record.

• I understand that my therapist may be required to fax or email treatment plans and diagnostic reports to my insurance carrier. I understand that in some instances, this information may be submitted to insurance data bases and/or employers when they are the purchasers of my medical/mental health benefits.

• I understand that different co-payments or co-insurance payments are required by various group coverage plans. I acknowledge that my co-payment is based on the Mental Health Policy selected by my employer or purchased by me. In addition, I am aware that the co-payment may be different for the first visit than for subsequent visits. I acknowledge that if I have a deductible, I may also be responsible for the contracted rate until all of my yearly insurance deductibles have been met.

• I understand that prior to my first visit, I am responsible for checking my insurance and EAP benefits including coverage, deductibles, preauthorization, number of sessions permitted, payment rates, co-payments and co-insurance.

• I understand that co-payments are collected at the time of service in the form of cash or check. If, at any time, a co-payment, statement, or preauthorization has been adjusted, I agree to notify my therapist. I understand that I will be required to pay the difference or will be given a credit if over billed. I understand that my therapist will make me aware of any credits or adjustments from the insurance company.

• I understand that if my insurance does not pay for services, I will be responsible for the balance due.

• I hereby authorize payment of medical benefits to Sarah Maurer, LPC, CCDP-D of Sunstone Counseling, LLC for all of the services described on the attached form.

• I understand that if I need to cancel an appointment, I am required to provide notification **at least 24 hours** in advance or I will be billed directly for the **full cost** of my missed session. I understand that if I am using insurance, I will be charged the **CONTRACTED RATE** for the cost of my missed session (e.g., if the contracted rate for Anthem Blue Cross Blue Shield is $90/session and my co-payment is $25, I will be charged $90 for the missed session). I understand that I may leave a message on the voice mail, which does have a time stamp. **PLEASE NOTE: INSURANCE COMPANIES WILL NOT PAY FOR MISSED APPOINTMENTS.**

**\_\_\_\_\_ I understand that my credit card on file will be charged for the full session amount if I fail to give 24-hour notice of a cancellation or miss my appointment.**

***If you are self-pay or elect NOT to utilize your insurance coverage -* Please initial after each item to indicate that you have read, understand and agree with the following items:**

\_\_\_\_\_ I understand that Sunstone Counseling LLC/Sarah Maurer, LPC, CCDP-D will not bill any third party insurance companies for any services or fees incurred while I am in treatment.

\_\_\_\_\_ I understand that I am solely responsible for any fees incurred while in treatment with Sunstone Counseling LLC/Sarah Maurer, LPC, CCDP-D

\_\_\_\_\_ I am aware of the fee per session ($100) for psychotherapy treatment with Sunstone Counseling LLC/Sarah Maurer, LPC, CCDP-D.

\_\_\_\_\_ I understand that I am financially responsible for missed appointments

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

Signature of client (or person acting for client) Date

Indicating agreement to all of the statements above

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

Printed name

**Client information and Consent Agreement**

This is to clarify our office policies, procedures and your rights as a client. Please read the information carefully and ask for clarification if anything is unclear to you.

**The Session**

The psychotherapy session is a 50-minute hour. I prefer that we take care of business items at the beginning of each session. This includes scheduling the next session and payment for the current session. This will ensure that your therapy time will be best utilized.

**Appointments**

Appointments can be made by calling 636-328-9700 or emailing sunstonecounseling@gmail.com. Please call to cancel or reschedule at least **24 hours in advance** or you will be charged for the missed appointment. Your insurance will not cover missed or late cancellation of appointments.

**Number of sessions**

The number of sessions needed depends on many factors and will be discussed between you and the therapist.

**Therapeutic Relationship**

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is of the utmost importance that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the therapeutic relationship and are strictly prohibited.

The therapist cares about you but is not in a position to be your friend or to have a social or personal relationship with you. Gifts, bartering and trading services are not appropriate.

**Confidentiality**

* All information between therapist and patient is held strictly confidential.
* By law, information about clients may only be released upon written consent of all parties treated or the person’s parent or guardian, except as allowed by federal and state law.
* In order to give you the highest quality service possible, I consult regularly with other professionals about my work with clients. I refer to clients on a first name basis (if that) and am happy to disclose to you the names of professionals that I may consult with.
* I keep all records for seven years after the last date of service, and after that shred them to protect your confidentiality.
* There are a few cases under which I am under both professional and legal obligation to release confidential information. They are in the following situations: cases of suspected child or elder abuse, when you confide or give strong indications that you may commit or have committed a crime or harmful acts to yourself or others, or to a court under court order. When records are requested by court order, it is my policy in such situations to provide a summary of treatment and charge you for my time.
* When meeting with couples, in order to provide the safest environment possible, it is my policy not to release information requested in the future for divorce proceedings that may ensue. When you sign this disclosure, you are agreeing not to subpoena my records in order to defame the character of your spouse in the process of a divorce, except in cases of clear, observable abuse that I have personally witnessed.
* If you have been directly referred to me by a clinician, physician, or other person, I may as a good business practice thank them for the referral. Please advise me if you prefer that I not do this.

Please let me know if you are not comfortable with me leaving brief messages on your voicemail or answering machine confirming, changing, or cancelling an appointment.

**Informed Consent**

I understand that I have voluntarily chosen to receive psychological services with Sarah Maurer, LPC, CCDP-D and that I may terminate at any time. I understand that there is work involved with therapy and that at times emotions may be painful. I understand that the therapeutic relationship is important and that I have the right to ask questions that will help me understand the process and address any concerns. I have the right to be informed of the various activities involved in therapy. I have the right to humane care and protection during therapy. I HAVE READ THE STATEMENT OF UNDERSTANDING AND AGREE TO COMPLY WITH ALL OF THE POLICIES AND PROCEDURES OF THIS PRACTICE.

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

Signature Date

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

Print

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

Sarah Maurer, LPC, CCDP-D Date

Copy given to client \_\_\_\_\_\_\_

**Primary Care Physician Consent to Use and Disclose Your Protected Health Information**

I authorize Sarah Maurer, MA, LPC, CCDP-D, to contact my Primary Care Physician regarding my medical conditions as well as information pertaining to my psychological and emotional functioning. This information will be useful in treatment planning. I authorize the release of the information verbally or in writing.

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last medical exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any physical impairments or disabilities? If so, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 I do NOT permit Sarah Maurer, MA, LPC, CCDP-D, to contact my Primary Care Physician

 I DO permit Sarah Maurer, MA, LPC, CCDP-D, to contact my Primary Care Physician

 I do not have a Primary Care Physician

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatrist Consent to Use and Disclose Your Protected Health Information**

I am currently under the care of a psychiatrist.

I authorize Sarah Maurer, MA, LPC, CCDP-D, to contact my psychiatrist regarding my mental health care, services, and treatment planning. I authorize the release of the information verbally or in writing.

Psychiatrist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 I do NOT permit Sarah Maurer, MA, LPC, CCDP-D, to contact my Psychiatrist

 I DO permit Sarah Maurer, MA, LPC, CCDP-D, to contact my Psychiatrist

 I do not have a Psychiatrist

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_