Counseling Agreement & Consent for Treatment

Cottonwood Creek Counseling
Individual, Couple, & Family Therapy

- **Benefits and Risks**: Active participation in therapy can result in a number of benefits, and most individuals experience improvement and healing during this process. Engaging in therapy can result in your experiencing considerable emotional discomfort as we address difficult issues in your life, propose ways of handling situations, and challenge your perceptions. Attempting to resolve therapeutic issues may also result in changes that were not initially intended. There is no guarantee that therapy will yield the intended results, and it is your decision whether to pursue the suggestions made by your therapist.

- **Confidentiality**: We cannot release any confidential information without a signed Authorization to Release Information form. We commit to keeping complete confidentiality, unless we learn of situations which we are required by law to report. These include: intent to harm self, intent to harm someone else, suspected abuse or neglect of a child, or suspected abuse or neglect of a vulnerable adult. If any of these are discussed in session, this will break confidentiality and a report will be made to the appropriate agency to ensure the safety of yourself and others.

- **Emergencies:** Cottonwood Creek Counseling **does not** provide emergency or crisis services and our therapists are not often immediately available by telephone. If you have an emergency and need to talk to someone please call 911 or the 24 hour National Crisis hotline at 1-844-493-TALK (8255) or go to your nearest hospital emergency room.

- **Fee schedule:** The standard fee is **$100.00** for a 50-55 minute therapy session and **$150.00** for a 60 minute initial assessment session. Payment is to be made at the beginning of each visit. Payment can be made by cash, personal check, credit card, debit card or Health Savings Accounts.

- **Missed Appointment and Late Cancellation Fee:** A **$50 fee** will be charged for missed appointments and cancellations made without **at least 24 hours prior notice**. Fees will be the Client and/or Responsible Party's full responsibility and will not be billed to any third party, including insurance and clergy. Cottonwood Creek Counseling may provide reminder calls as a courtesy; however it is your sole responsibility to keep track of and attend all scheduled therapy appointments.

- **Disclosure Statement:** Jennifer Fairbourn is a Licensed Marriage and Family Therapist registered in the state of Utah. Her education includes a B.S. degree in Family Science from Brigham Young University (1999) and an M.S. degree in an AAMFT Accredited Program in Clinical Marriage and Family Therapy from the University of Maryland (2007).

- **Email:** Please use discretion in deciding whether to communicate with your therapist via email. Confidentiality cannot be guaranteed when using email communications and Cottonwood Creek Counseling cannot be held responsible for any information lost in transit or viewed by unauthorized third parties.

- **Social Media**: Cottonwood Creek Counseling and its therapists may have a business Facebook page, educational blog, or other social media accounts. If you choose to like, post comments, or follow these accounts there is a chance that others will see your name associated with the social media and we cannot guarantee any confidentiality or protection to your identity as it may be linked to these accounts. Please use at your own discretion.

Your signature below indicates that you have read and understood the Counseling Agreement and Consent for Treatment and agree to the standards set forth.

_____	_____	_____
Print Name of Client or Responsible Party	Signature of Client or Responsible Party	Date

Authorization for Release of Information

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By initialing and signing, I authorize that Cottonwood Creek Counseling and the individuals and entities listed below may mutually disclose and release my personal health information for the purpose of payment, diagnosis, treatment, coordination of care, and other therapeutic purposes. This may involve the exchange of any records including assessments, reports, clinical test results, professional opinions, and all information relating to psychological, medical, educational, and any other pertinent information. I understand that a photocopy or facsimile of this consent shall have the same effect as the original.

Upon request, I may revoke this authorization at any time by sending a written notice to Cottonwood Creek Counseling. Any disclosures that have been made to the individuals or entities listed below prior to this written notice however will not be affected by the revocation.

I understand that the information used in this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by the confidentiality regulations of Cottonwood Creek Counseling. In listing individuals and entities below, I waive my right of privacy of information disclosed that is hereby authorized. This authorization is only valid during treatment at Cottonwood Creek Counseling and up to three months after termination or completion of treatment. I understand that if I wish to have information from my personal file disclosed after this time period, a new authorization will need to be completed and I may be charged a $25 fee to access closed files.

Name/Entity	Address/City	Phone	Initial
Insurance:			
Medical:			
Other:			
Other:			
Other:			

_____ _____ _____
Print Name of Client or Responsible Party | Signature of Client or Responsible Party | Date

_____ _____ _____
Print Name of Client or Responsible Party | Signature of Client or Responsible Party | Date

_____ _____ _____
Print Name of Witness | Signature of Witness | Date

Parent/Guardian Authorization for Treatment of Minor: (as applicable)

I authorize that my child _____ (Date of Birth: _____) may engage in services provided by Cottonwood Creek Counseling. I understand that I am giving consent for my child to meet one on one with the therapist and also agree that parental involvement may be required during the course of treatment including: family counseling, parenting skills training, co-parenting sessions, and the therapist's exchange of information with the other parent.

_____ _____ _____
Print Name of Parent 1 | Signature of Parent 1 | Date

_____ _____ _____
Print Name of Parent 2 | Signature of Parent 2 | Date

Financial Agreement

-**All fees for services** rendered (including copays) are due and payable at the time of service.

-**Insurance:** Cottonwood Creek Counseling will communicate with insurance companies as a courtesy, however it is the responsibility of the Client and/or Responsible Party to follow up with the insurance company to confirm 1) in/out of network benefits, 2) needed authorizations, 3) copays, 4) deductibles, and 5) number of allowed visits.

-**Other Third Party Billing:** Cottonwood Creek Counseling will communicate with other third party billing such as Clergy, Government, and Employee Assistance as a courtesy; however, it is the responsibility of the Client and/or Responsible Party to follow up with the outside agencies to confirm payment arrangements have been approved and prompt payments are made.

-Denial of Coverage from Insurance or Third Party Billing: The Client and/or Responsible Party assume full responsibility for any denial of coverage from any third party billing or insurance. All payment for the unpaid/denied amounts will be due and paid by the Client and/or Responsible Party within 15 days of notification of denial.

-No Show and Late Cancelation Fees will be the Client and/or Responsible Party's full responsibility and will not be billed to any Third Party, including Insurances and clergy. Payment in full for these fees is due within 15 days after they are incurred.

-Returned Check Policy: If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC) or Refer to Maker (RTM), the Client and/or Responsible Party will be responsible for the original check amount as well as a $20.00 service charge. If the returned check and fee are not paid in full within 15 days from the date Client and/or Responsible Party is notified, the account may be turned over to our collection agency.

-Non-Payment on Account: Should the Client have a delinquent account, a $30.00 late fee will be added to your bill every additional 30 days the bill is unpaid. The Client and/or Responsible Party understands that Cottonwood Creek Counseling has the right to pursue legal action and disclose to an attorney or outside collection agency all relevant personal and account information necessary to collect payment for services and applicable fees. In addition, the Client and/or Responsible Party understand that they are responsible for all additional costs of collection on the delinquent account.

- **Terms and Conditions:** If there is any default or breach hereof and any legal action is necessary to enforce the terms of this agreement, the Client and/or Responsible Party agrees to pay Cottonwood Creek Counseling's reasonable attorney's fees and court costs in addition to any other relief to which it may be entitled if client fails to pay any amounts owing hereunder when due, or otherwise breaches any terms of this Agreement. Client and/or Responsible Party agrees to pay for collection expenses incurred in attempting to collect such amounts from Client, in addition to the aforementioned attorney's fees and costs.

Your signature below indicates that you have read the Financial Agreement and forms a binding contract with Cottonwood Creek Counseling that you will be financially responsible for payment of any and all charges relating to counseling services and applicable fees as indicated above.

_____	_____	_____
Print Name of Client or Responsible Party	Signature of Client or Responsible Party	Date

Assessment Questionnaire — Adult Individual

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Client Name: **Date of Birth:** **Gender:**

***Current Symptoms Checklist** (check once for any symptoms present, twice for major symptoms)**:**

( ) Depressed mood	( ) Racing thoughts	( ) Excessive worry
( ) Unable to enjoy activities	( ) Impulsivity	( ) Anxiety
( ) Changes in sleep: increase/decrease	( ) Increase in risky behavior	( ) Panic attacks
( ) Loss of interest	( ) Changes in sex drive: increase/decrease	( ) Hallucinations: visual/audio
( ) Difficulty with concentration	( ) Forgetfulness	( ) Suspiciousness or paranoia
( ) Change in appetite: increase/decrease	( ) Excessive energy	( ) Avoidance/Isolation
( ) Excessive guilt or shame	( ) Increased irritability	( ) Change in desire/motivation
( ) Fatigue	( ) Crying spells	( ) _____
( ) Mood swings	( ) Obsessions	( ) _____

***Presenting Problem** (What are you seeking help for? Describe physical and emotional symptoms—onset, intensity, frequency. When did challenges begin?):

***Major Life Events in the Past Year** (moves, job changes, deaths, births, illnesses, accidents, injuries, graduation, retirement, empty nest, etc.):

***Past History of Therapeutic Treatment** (type, presenting problem, when, duration, effectiveness, why discontinued):

***Attempts to Resolve Presenting Problem** (techniques/resources, duration, effectiveness):

Cottonwood Creek Counseling – 7321 S. State St. Ste. A, Midvale, Utah, 84047 – (801) 878-4327

***Risk Factors** (Present or history of any thoughts, feelings, or actions regarding: suicide, self-harm, homicide, eating disorder, domestic violence, infidelity?):

***Spirituality** (Do you identify with a specific religion or belief system, interact with clergy/bishop, attend meetings, comfort level using in therapy?):

***Strengths and Support System** (describe friends and family support, your personal strengths, desire and commitment to make changes):

***Challenges** (what will be difficult for you in making desired change? Impatient, stubborn, disabilities, lack of support, etc.):

***Relationship Status** (single/dating/married/separated/divorced/widowed, length of relationship, satisfaction, previous relationships):

***Individuals living in the home** (name, relation, age)**:**

***Other immediate family members not living in the home** (name, relation, age)**:**

***Employment** (company, position, number of hours per week, length of time with company/position, satisfaction, difficulties):

***Education** (highest level completed, learning disabilities, strengths, weaknesses):

***Mental Health History** (personal and family history of: depression, anxiety, OCD, bipolar, schizophrenia, psychiatric hospitalization; diagnoses received):

***Current Medications** (name, purpose, dosage, effectiveness, side effects, start date, date of last adjustment, doctor prescribing medication):

***Medical History** (personal: surgeries, major illnesses, chronic pain, formal diagnoses; family history):

***For Women Only:** Any difficulties with menstruation:_____

Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Birth control method _____ (if applicable)

How many times have you been pregnant? _____ How many live births? _____

***Alcohol and Substance Use** (alcohol, cigarettes, tobacco, chew, recreational substances, others [indicate present or past and frequency]):

***Dependence/Addiction History** (present and past: drug and alcohol, caffeine, sexual, pornography, gaming, social media, spending, gambling):

***History of Abuse** (physical, sexual, rape, trauma: when, how long did it continue, was a report made, current safety measures if necessary):

***Goals you desire to accomplish through therapy**:

***Additional Information (use back of page if needed)**

Person filling out form: _____ _____ _____

Print Signature Date