PURPOSE

Saving Souls Through Social Work and Therapy

Client Information

Name: _____ Date:_____

Address: _____
Street City state zip

Email: _____ Cell Phone: _____

Home Phone: _____

Birthdate: _____ Age: _____

Emergency Contact

Name: _____

Address:_____
Street City state zip

Email: _____ Cell Phone: _____

Home Phone: _____

Birthdate: _____ Age: _____

Relationship to client: _____

How did you hear about me? _____

Family History:

Substance use: Yes or No who? _____ what? _____

Mental illness: Yes or No who? _____ what? _____

Trauma History

History of Trauma (physical/sexual/emotional abuse, death of a loved one, exploitation, etc.):

_____

_____

_____

_____

_____

Have you participated in therapy in the past? Yes or No If yes, tell me about your experience of therapy (positive, negative, mixed, etc.): _____
_____
_____
_____
_____

History of self-harm: _____

Suicide attempts: _____ how many? _____

Suicidal ideation: _____

Homicidal ideation: _____

Auditory/Visual Hallucinations: _____

Substance use: _____

Type of substance: _____

How long have you been using? _____

What would you like to gain from our work together (therapy goals):

_____
_____
_____
_____

FEES/PAYMENT: *(Please initial at each line)*

_____ I/We understand that the fee for individual therapy is $95 per 60min session. Family therapy/couples therapy is $120 per 60min session. Sliding pay rates available with proof of income (tax returns, pay stubs, etc.). Therapist can provide sliding fee scale upon request. All checks made payable to **Purpose, PLLC**. I/We accept responsibility for the payment of services at the time they are rendered. Purpose, PLLC. accepts cash, credit, money order, and personal checks. **Please do not initial if you are receiving a sliding scale. You will receive a separate financial agreement.**

_____I/We also accept responsibility for payment of $35 (for individual therapy) and $50 (for family therapy) for no call/no show sessions. *All cancellations are to be made within 24 hours of the scheduled appointment time by text, email, phone w/voicemail. When cancellations are made within the above timeframe and appointment rescheduled, there will*

be no cancellation fee applied. Therapist may request for a credit card to be kept on file in order to charge for no call/no shows. Therapist will provide a credit card authorization form with intake documents. By completing that form, you are in agreement with specified charge amount.

_____*SNOW DAY POLICY*- All cancellations are to be made within 24 hours of the scheduled appointment time by text, email, phone w/voicemail.

_____*INVOLVEMENT IN THERAPY – CONSISTENCY OF APPOINTMENTS:*
You and your family have a right to terminate or quit therapy at any time. Please inform therapist at least *7 days* prior to termination. Unless other arrangements have been made in advance, if you miss or do not schedule appointments for three consecutive weeks without any communication, for legal and ethical reasons, I must consider the professional relationship discontinued. I may then offer the time spot to another individual in need. If you wish to resume services, I may or may not have a spot available at the previously established rate, so we would be creating a new arrangement. As long as you are in therapy, I strongly encourage you to keep all scheduled appointments. Life can be busy, and things get in the way. Therapy is an investment in your well-being and health. Making time for it can be a major step forward. Talk to me if you are having difficulty keeping appointments.

Therapy works best when you come to sessions with goals and ideas about what you want to address for the session. Please give me feedback about our work together. These are your sessions.

Sometimes in the course of therapy, individuals or family members may feel more pain, discomfort, or upset as issues are explored. Please let me know if that is happening to you or one of your family members.

_____*FAMILY SECRETS:*
When I am working with families, I have a "no secrets" policy. This means that as a therapist, I will not keep significant secrets about the family from others participating in therapy, if it impacts the therapeutic process and goals of our work together. The items shared in individual therapy will not be shared in the family therapy sessions, unless therapist suggest that client share information for therapeutic purposes.

_____Please be aware that this therapist is a mandatory reporter which mandates the reporting of information that pertains to someone being hurt by someone else or someone hurting themselves to the local Department of Human Services.

_____*LIMIT OF SERVICES AVAILABLE*: I do not provide emergency and after-hours services. If you find yourself in a life-threatening situation, you agree to take the necessary steps to keep yourself safe, up to and including calling 911, calling a hotline or going to the emergency room (at your cost), if necessary. I do not provide medications, psychiatric services, or psychological testing. I do not provide evaluations for emotional support animals.

_____ *IN HOME THERAPY:* Therapist can provide in home individual/ family therapy sessions at the request of the client and the availability of the therapist. If this is something that you are interested in, please inform therapist at least *7 days* prior to the designated appointment time. I/WE agree to provide a clean and private space free of distractions for

entire time of therapy session. Therapist must be informed of all weapons, animals or other possible safety concerns within the home prior to therapy session.

_____*TELEHEALTH SERVICES*: Telehealth therapy sessions offered via a HIPPA compliant platform. Therapist will talk with client about getting connected with the platform. All payments will be made at the end of session via Square. Client will ensure a private space free from distractions for 60 min therapy sessions. Therapist will ensure the same and that client confidentiality is upheld. Therapist will wear a headset to ensure client confidentiality. Therapist may request for client to give a full view of the space to ensure there is no one else present in session. Therapist and client are always expected to be fully dressed during session. The backup plan, if there are technical difficulties, will be to call therapist's number 719-749-1143 within 5mins of disconnection. Therapist will attempt to reconnect 3 times and if unsuccessful, therapy session will continue as a phone session. Please see telehealth informed consent for further information.

_____ *CONFIDENTIALITY*: Please be advised that I cannot assure that confidentiality is maintained through text and cell phone communication; and that should only be used to arrange appointments. However, therapist will exercise good practice in maintaining HIPPA standards. Email communication is conducted through Protonmail, which is an encrypted email service. Please communicate all personal information via email or face to face communication. Any correspondence via phone or text is on a password protected device. Any electronic PHI will be stored password protected as well. All paper documents will be stored in a locked file cabinet and therapist will only have access to those documents. If third party is requesting documentation, a Release of Information will have to be completed by the client's guardian. All client files will be kept for 7 years then destroyed by water. If there are any breaches to confidentiality, client and guardian will be informed in writing within 24hrs of discovery of breach. If you have any questions, please discuss with therapist.

I have read, understand, and agree to these policies above.

Client Name: _____

Signature: _____

Date: _____