**Water Street Family Counseling**

*Serving Children, Adults, Couples and Families*

117 North Water Street

Liberty, MO 64068

 *Today’s Date* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Date of First Appointment* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADULT CLIENT INFORMATION**

|  |  |  |
| --- | --- | --- |
| First Name | Middle Initial: | Last Name |
| If your legal name is other than above, please print here:  | Birth Date: | Age: |  |
| May we leave a message on your home phone? Y N May we leave a message on your cell? Y N Can we text you appt reminders? Y NCan we send any mail to your home? Y N | Home Phone: ( )Cell Phone: ( ) | Work Phone:( )Ok to call? Y NOk to leave message? Y N |
| Street Address: | City: | State: | ZIP Code: |
| Occupation: | Employer: |  |
| Referred by (may be more than one) | Dr. | Insurance Plan | Psychology Today |
| Family | Friend | Close to home/work | Website  | Other (list) |

**EMERGENCY INFORMATION AND RELEASE**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of local friend or relative: | Relationship to client: | Home phone number:( ) | Cell phone number:( ) |
| The above information is true to the best of my knowledge. I authorize my therapist to contact the emergency contact listed above if warranted.  |
| *Client Signature:* | *Date:* |

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Liberty, MO 64068

**PERSONAL HEALTH HISTORY**

**List any medical or physical problems, hospitalizations, and surgeries; include when they were diagnosed**

|  |  |  |
| --- | --- | --- |
|  |  |  |
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**List all prescription and over-the-counter drugs you are taking: Any Allergies:**

|  |  |
| --- | --- |
|  |  |
|  |  |

**HEALTH HABITS AND PERSONAL SAFETY**

|  |  |
| --- | --- |
| **Exercise** | No Exercise |
| Moderate exercise  |
| Regular exercise  |
| Yoga |
| **Nutrition/Sleeping** | Are you concerned about your nutrition or eating patterns?  | Yes No |
| Are you concerned about your sleeping patterns?  | Yes No |
| Have you spoken with your doctor about any of these concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Suicidal Thoughts**  | None at this time Yes, I am having thoughts now |  In the past I have thought about it | I have attempted suicide before | I have been hospitalized for depression before |
|  **Alcohol** | Do you drink alcohol? | Yes No |
| If yes, what kind? |
| How many drinks per week? | Yes No |
| Are you concerned about how much you drink? | Yes No |
| Have you considered stopping? | Yes No |
| Have you ever experienced blackouts? | Yes No |
| Are you prone to “binge” drinking? | Yes No |
| Do you drive after drinking? | Yes No |
| **Tobacco** | Do you use tobacco? | Yes No |
| Cigarettes - pks./day: |  |
| # of years:  | Or year quit: |
| **Personal Safety** | Do you have any legal concerns? | Yes No |
| Do you have a history of any type of abuse? Physical, sexual, emotional or neglect? Yes No |
| Is there any type of abuse happening in your life or home now? | Yes No |
|  | Are you concerned about you or anyone in your family hurting themselves or each other? | Yes No |
|  | Do you ever feel afraid of your partner or another person? Have you ever had an Order of Protection? | Yes No |
|  | Do you ever have concern about the use of prescription medication in your home? | Yes No |
|  | Are you worried about child abuse or elderly abuse by (or to) anyone in your family?  | Yes No |

**Water Street Family Counseling**

**Concerns and Strengths**

Which specific concerns or issues brought you to therapy at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have these concerns been causing you distress?

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Do you have family or friends who you turn to for emotional support/help with problems?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please list major changes you or your family have experienced during the past 5 years: (births, deaths,

health issues, moving, divorce, job, witnessing/experiencing traumatic event):

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

How will you know when your issues are improving? What will be different for you and/or your family?

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What would you say is a strength of yours or your family?

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Is there anything else you feel that is important for your therapist to know?

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| --- | --- |
| Is stress a major problem for you? | Yes No |
| Do you feel depressed? | Yes No |
| Do you panic when stressed? | Yes No |
| Do you have problems with eating or your appetite? | Yes No |
| Do you cry frequently? | Yes No |
| Have any family or friends suggested you seek counseling? | Yes No |
| Have you ever seriously thought about hurting yourself? | Yes No |
| Do you have trouble sleeping? | Yes No |

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|  |
| --- |
| **Authorization to treat** |

|  |
| --- |
| I give my consent to my therapist to provide assessment and therapeutic services to me/my child, within the scope of his/her license. I understand that my therapist will work with me to develop a treatment plan and treatment will be formulated to resolve my problem(s) as quickly as possible. I agree to cooperate with my therapist in the treatment process to carry out therapeutic homework assignments and to follow through with any medical treatment, as prescribed by my physician. I further agree to keep my, or my child’s scheduled appointments and understand that failure to do so more than two times may result in my care being terminated.By signing below, I agree to payment and arrangements set forth, affirm that all my questions have been satisfactorily answered, and I give informed consent for myself/my child’s treatment. I understand that I will be furnished a copy of the consent whenever I request it.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client Signature/Responsibility Party Date |

|  |
| --- |
| **Authorization to treat minor child** |

|  |
| --- |
| Name of Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I warrant that I am a custodial parent of the above named minor child. I hereby give permission for him/her to receive counseling. I acknowledge that I am aware of the mandating reporting laws in the state of Missouri. I am also aware that I can withdraw the permission to treat my child at any time. I will assume responsibility to notify my child’s other parent that counseling has been initiated and will take sole responsibility in arranging for the payment for all counseling services for my child.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client Signature/Responsible Party Date |

|  |
| --- |
| **Professional Disclosure Information (HIPAA)** |

|  |
| --- |
| Your signature below indicates that you have read our HIPAA agreement and agree to its terms and serves as acknowledgement that you have received our HIPAA notification form. Not abiding by these policies may lead to termination of our work together and/or referral to another professional.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client Signature/Responsible Party Date |

**Water Street Family Counseling**

117 N. Water Street

Liberty, MO 64068

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| --- |
| **Client Rights/Notice of Privacy Practices** |

**This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

Effective Feb. 21, 2012.

**YOU HAVE THE RIGHT:**

1. To be treated with consideration and respect.
2. To expect quality services provided by concerned, competent staff.
3. To a clear statement of purposes, goals, techniques, rules of procedure and limitations, as well as potential dangers of the services to be performed, plus all other information related to or likely to effect the on-going counseling relationship.
4. To obtain information about the case record and to have the information explained clearly and directly.
5. To full knowledgeable and responsible participation in the on-going treatment plan.
6. To expect complete confidentiality and that no information will be released without written consent.
7. To see and discuss charges and payment records.
8. To refuse any recommended services and be advised of the consequences of this action.
9. To request where we contact you (home, work, cell) and whether we should leave a message.

**THERAPISTS’ CREDENTIALS:**

Victoria Ford, M.S., LMFT, is a Licensed Marriage and Family Therapist in the state of Missouri. She is bound by the Code of Ethics set forth by the American Association of Marriage and Family Therapists (AAMFT) and other professional governing boards, and clients can request a copy of these ethics at any time. Victoria is an independent practitioner.

Holly Hemphill, M.S., LMFT, is a Licensed Marriage and Family Therapist in the state of Missouri. She is bound by the Code of Ethics set forth by the American Association of Marriage and Family Therapists (AAMFT) and other professional governing boards, and clients can request a copy of these ethics at any time. Holly is an independent practitioner.

Jennifer Kempema, M.S., ATR-BC, is a Registered Art Therapist, Board Certified. She is bound by the Code of Ethics set forth by the American Counseling Association and other professional governing boards, and clients can request a copy of these ethics at any time. Jennifer is an independent practitioner.

Alicia Kiser, M.Ed, LMFT, is a Licensed Marriage and Family Therapist in the state of Missouri. She is bound by the Code of Ethics set forth by the American Association of Marriage and Family Therapists (AAMFT) and other professional governing boards, and clients can request a copy of these ethics at any time. Alicia is an independent practitioner.

Carmen McHenry, M.A., LPC, is a Licensed Professional Counselor in the state of Missouri. She is bound by the Code of Ethics set forth by the American Counseling Association and other professional governing boards, and clients can request a copy of these ethics at any time. Carmen is an independent practitioner.

Heidi Tolnai, M.A., LPC, is a Licensed Professional Counselor in the state of Missouri. She is also bound by the Code of Ethics set forth by the American Counseling Association and other professional governing boards, and clients can request a copy of these ethics at any time. Heidi is an independent practitioner.

**CONFIDENTIALITY OF INFORMATION:**

Laws insuring your right to privacy protect matters discussed with your therapist. In most cases, your therapist is prohibited from disclosing information about your care without your written consent and then only to the extent you authorize. Cases where information may be disclosed without your consent include:

1. When child abuse is known or suspected (reporting is required by law).
2. When the abuse of an elderly or depended person is known or suspected (required by law)
3. If you commit a crime against a staff member of another person in the premises,
4. If there is a situation that is potentially life threatening.
5. When the court subpoenas the records.

Water Street Family Counseling team consultation: Therapists at Water Street Family Counseling offer case consultation for one another, in the interest of offering the best practice care and resources to our clients. Client names are not used during case consultation, and all therapists abide by the same confidentiality laws.

**Client Rights/Notice of Privacy Practices page 2**

**SECURITY OF RECORDS:**

Your records of treatment and related financial records are kept confidential. Records will not be made available to others without signed authorization by the client to release information. The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by state and federal laws and the ethics of the counseling professions as private information. All adults present in couples or family sessions have to authorize the release of records. Clients have access to their therapy records. Therapists recommend reviewing records with clients to avoid misinterpretation. We respect the privacy of the information you provide us, and we abide by ethical and legal requirements of confidentiality and privacy of records. Violation of privacy laws by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Clients have the right to be informed about changes in privacy policies.

**RETENTION OF RECORDS:**

Treatment records are retained for a period of at least 10 years following the termination of treatment. At the end of that period the records are destroyed in a manner that assures the confidentiality of the information unless the client requests otherwise, in writing, prior to the destruction of records.

**INFORMATION REGARDING PSYCHOTHERAPY:**

1. Psychotherapy may involve remembering unpleasant events and can arouse intense emotions of fear and anger; feelings of anxiety, depression, frustration, loneliness and helplessness may be experienced. Also feelings of relief, energy, power, self-acceptance, and well-being may also occur.
2. Psychotherapy is not always effective and may, in some cases; result in deterioration rather than improvement of a client’s psychological functioning. Psychotherapy has been shown effective in about 75% of cases.
3. There are numerous forms of psychotherapy, which vary, not only underlying theory and methods employed, but also in terms of time commitment and cost. We will attempt to provide treatment that is realistic in both areas.
4. Depending upon a client’s condition, there may be available alternatives to psychotherapy, such as medication or behavior modification; we will make these recommendations if they are appropriate, based upon our assessment.

**TERMINATION OF THERAPY:**

A client may be terminated from Water Street Family Counseling nonvoluntarily if (a) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at Water Street office, (b) the client refuses to comply with treatment recommendations, (this may include repeated no shows, reschedules or late cancellations) (c) the client does not make payment or payment arrangements in a timely manner. Clients may voluntarily leave treatment at any time, and, it is recommended that clients discuss this with the therapist in person. This will help facilitate a more appropriate plan for discharge.

**OFFICE HOURS/EMERGENCIES:**

Water Street Family Counseling includes several therapists who are all independent practitioners. Therefore, each individual therapist has office hours and counseling session that are by appointment only. We are unable to provide counseling services to clients who require 24 hr. care/crisis intervention services, and may be unable to provide immediate crisis intervention or emergency assistance. Therapists check their confidential voicemail as often as possible, and strive to return phone calls promptly. Talk with your therapist about their specific hours; some therapists are part time and it could be a few days before you receive a returned call. For medical or life-threatening emergencies, call 911 or contact nearest emergency room at your local hospital. **Do not use email or texting as methods to communicate that you are in crisis** **with your therapist.** Texting and email are often appropriate for scheduling communication; for further information sharing or questions, communicate with your therapist by phone or in session.

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Client/Guardian Signature Relationship to Client Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client/Guardian Signature Relationship to Client Date

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Therapist Signature Date