**Registration Form**  Today’s Date:

**Client Name**: DOB: Age:

Primary Address:

City: State: Zip:

Emergency Contact: relation:

Phone #: Email:

Parent Name: DOB:

Primary Address:

City: State: Zip:

Phone #: Alternative Phone #:

Email:

Parent Name: DOB:

Primary Address:

City: State: Zip:

Phone #: Alternative Phone #:

Email:

Step-Parent Name: DOB:

Primary Address:

City: State: Zip:

Phone #: Alternative Phone #:

Email:

How does the client get along with other siblings?

Great Good Fair Poor

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| --- | --- | --- | --- |
| **Name** | **Age** | **Date of Birth** | **Lives in Household Y/S** |
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|  |  |  |  |

Education: Grade Level:

Hobbies:

Previous Psychotherapists and/or Psychiatrist and estimated year:

Previous/current Mental health diagnosis:

Previous medication use that was not useful:

Current **medication and dosage**:

Current Psychiatrist: Phone #:

Is it ok to contact psychiatrist if needed?

Please indicate reasons for seeking counseling services by marking (***X****)* all that apply:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Abuse (sexual, emotional, physical) |  | Depression |  | Noncompliance |  | Social anxiety |  |
| Alcohol/drug use/abuse |  | Divorce/separation of parents |  | OCD patterns |  | Staying asleep |  |
| Anger management |  | Fatigue |  | Oppositional and defiant behaviors |  | Stress |  |
| Anxiety |  | Fear/phobias |  | Peer relationships |  | Suicidal ideation |  |
| Attention difficulties |  | Grades dropping |  | Physical aggression |  | Tantrums |  |
| Bed wetting |  | Grief |  | Sadness |  | Verbal aggression |  |
| Body-focused repetitive patterns (Skin picking, hair pulling, nail biting) |  | Hyperactivity |  | Self-esteem |  | Other: |  |
| Bullying |  | Life transition |  | Self-injurious behaviors |  | Other: |  |
| Boundary difficulties |  | Insomnia |  | Sensory issues |  | Other: |  |
| Body image |  | Nightmares |  | Separation anxiety |  | Other: |  |

When did issues/stressors become a problem?

Is there anything else that you would like the counselor to know about you?

**Rates of Service**:   
Initial visit and follow up appointments = $60  
First missed/late broken appointment = $45, Any more missed/late broken appointments =$60

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| --- |
| **Financial information** |
| Please provide your most up to date Credit Card/ Debit Card information, to be authorized for the payment of any fees not collected at the time of services, including; broken appointment fees. The information collected will only be managed by this therapist and will be encrypted and stored with your HIPAA compliant medical chart.  Please bring card in hand to be processed at the time of the appointment. |
| **Signatures of cardholder: Date:** |
| **Type of Card: Card Number:** |
| **Expiration Date (mm/yyyy): Security Number on back of Card:** |
| **Exact Name on Card: Zip code for Card:** |

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| --- |
| **Consent for Treatment and Practice Policy** |
| Your signature below indicates that you understand and agree to the Informed Consent Document. In divorced situations, both biological parents must give written consent for treatment. |
| **Signature: Date:** |
| **Print Name: Parent/Guardian print and sign:** |

**Informed Consent Document**

Welcome! I am a Master’s level Provisional Licensed Professional Counselor. I am currently under the supervision of Michelle Parker (License #: 2010012650). Please carefully read this document, for it contains important information about my professional services and business policies. Although these documents are long, it is very important that you understand them. When you sign this document, it will represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

**PROFESSIONAL COUNSELING SERVICES**Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Counseling has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, counseling has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Counseling requires a very active effort on your part. To be most successful, you should work on things we discuss outside of sessions.

Often children have difficulty sitting still and talking about what is on their mind. Play therapy provides toys to help children express what they need to say. Play is considered a natural form of communication for children. When children play out their feelings in a supportive, nonjudgmental, and accepting environment, they often feel better. Children have the capacity to learn how to express their thoughts and feelings in appropriate ways, how to be responsible for their behavior, and how to make choices.

It is advised not to ask your child any questions about the play therapy appointment and instead let them know that it is their special time with the counselor and they can decide whether they want to share with their caregivers and family members if they choose to do so.

# **APPOINTMENTS**

The first appointment will be a parent meeting with counselor to ask questions and discuss further details of the counseling process. Appointments with children will ordinarily be 40-50 minutes in duration, dependent on the client’s attention level, once per week, at a time we agree upon; although sessions may be as frequent as needed. Caregivers and family members may use the remainder of the 50-minute scheduled session to report of any changes at home or school and to schedule future appointments. About every three weeks, it would be appropriate to schedule a parent meeting to discuss the client’s progress made in therapy. If you need to cancel or reschedule a session, I ask that you provide me with 24-hours notice. If you miss a session without canceling, or cancel with less than 24-hours notice, my policy is to charge $45 for the first missed or broken appointment, and $60 for any other missed or broken appointment. You will be responsible for the fee as described above. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

# **Payments**

Counseling appointment charges and broken appointment fees are due at the time of your appointment. For ease of payment for counseling fees, please provide credit card information to be added to your account. Your credit card will be charged, the day of your appointment, for services. The credit card information will be stored in a secure, confidential file with your chart records.

# **RECORDS**

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you and the child were here, reasons for seeking therapy, any artwork that the child completes, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and billing records. Any emails containing information that is relevant to your treatment, will be added to your chart. Due to confidentiality issues, I would recommend that email correspondence be limited to scheduling appointments. You also have the right to request that a copy of your file be made available to any other health care provider at your written request. If at any time, you wish to share (or revoke) your information to a third party, a written release must be signed. Step parents do not have legal access to a minor’s health records unless both biological parents give verbal consent to do so or if the step parent has legally adopted the minor.

# **LIMITS OF CONFIDENTIALITY**

Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian. Noted exceptions are as follows: Duty to Warn and Protect, Abuse of Children and Vulnerable Adults, Prenatal Exposure to Controlled Substances, Minors/Guardianship. If the caregiver or family member is a legal guardian, you must bring in paperwork stating so.

# **CONTACTING ME**

At times, I am not immediately available by telephone or email. I do not answer my phone or return emails when I am with clients, out of the office, or otherwise unavailable. Should you need to reach me, you may leave a message on my confidential voice mail (888) 927-2785 or email (carron@westcocounseling.com ) and I will respond as soon as possible. Please note that it may take a day or two for non-urgent matters. If you do not hear from me or I am unable to reach you, and you feel you cannot wait for a response because you feel unsafe: 1) contact Behavioral Health Response at (314) 469-4908, 2) go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice. I am unable to respond to text messages or social media requests, due to confidentiality issues (HIPAA) and Ethical Codes of Conduct, defined by the American Counseling Association (ACA).

OTHER:  
If you are unhappy with what is happening in therapy, I hope you will speak with me, so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social relationships with clients or with former clients.

**Jill Carron, MS, PLPC**  
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