3200 Summit Blvd #15144
WPB, Florida 33416
Telephone: (561) 406-4424

Christian Counseling Services

Client Information

Client Name: _____ Date: _____
First MI Last (Maiden)

If client is a minor, please supply name of Parent or legal guardian: _____

Address: _____ City, State, Zip: _____

Phone Numbers to Contact/Leave Messages Circle one

Primary: _____ (Home / Work / Cell / Fax) Birth Date: _____ Age: ____

Secondary: _____ (Home / Work / Cell / Fax) Marital Status: ____ Single _____ Married

Other: _____ (Home / Work / Cell / Fax) ____ Widow ____ Separated ____ Divorced

Email Address: _____ Spouse Name: _____

Name Age Name Age

Children: _____ ____ _____ ____

_____ ____ _____ ____

Please list names of individuals with whom the Miranda Wrights Company, LLC may leave messages:

_____ _____ _____ _____
Name Relation Name Relation

_____ _____ _____ _____
Name Relation Name Relation

At this time we do not accept insurance.

Level of Education Completed: _____ School: _____

Employer: _____ Occupation: _____

Church/Affiliation: _____ Referred by: _____

Reason for seeking counseling: _____

_____

_____

Consent to Counseling

This form is to document that I, _____, give my permission and

consent to **Miranda Wrights Company, LLC** to provide counseling to me and/or

_____, who is/are my spouse/child(ren)/

_____.

While I expect benefits from this counseling service I fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed. I understand that because of the counseling, I/he/she/we may experience emotional strains, feel worse during counseling, and make life changes which could be distressing.

I understand that this counselor is not providing an emergency service and I have been informed of whom to call upon in an emergency or during weekend and evening hours. I understand the counselor is a consultant and a professional resource only, whose intervention may be freely accepted or rejected by the client, therefore, decisions made during and after counseling are the responsibility of the client. I understand that regular attendance will produce the maximum benefits but that I am/are free to discontinue counseling at any time. I understand that the client is free to terminate services at any time. I understand that **Miranda Wrights Company, LLC** is allowed to cancel the counseling services at any time, especially if therapy is recommended by a licensed professional.

I understand that conversations with the counselor will be confidential except as allowed by the Privacy Policy of **Miranda Wrights Company, LLC**. However, I understand there are limits to confidentiality based on payment methods, wireless and electronic communication that I elect to utilize. I further understand that Florida law requires any counselor who has reasonable cause to suspect child or elder abuse, neglect and abandonment/exploitation to report such knowledge to the appropriate authorities. I also understand that Florida law allows the confidentiality between the counselor and client to be waived when there is a clear and immediate probability of physical harm to the client, to other individuals, or to society and the counselor communicates the information only to the potential victim, appropriate family members, law enforcement or other appropriate authorities.

I understand that I am financially responsible for counseling services and for any portion of the fees not reimbursed or covered by third parties. **Miranda Wrights Company, LLC.** does not accept insurance at time. I also understand that I am expected to pay for the counseling fees at the time of the visit and any arrangement for payments by third parties will be made before the counseling session. I understand that receipts will be provided for at each request.

I understand that the appointment with a counselor is, in a sense, a contract whereby the client has exclusive use of the counselor's time for the scheduled appointment. I also understand that the client is held responsible for the fee for all cancelled appointments; however, if the cancellation is done at least 24 hours in advance of the appointment, there will be no charge for the cancellation. Appointments are 50 minutes in length unless otherwise agreed upon with the counselor.

Cancellation of Appointments

To avoid paying for cancelled appointments, the undersigned agrees to call **Miranda Wrights Company, LLC.** 24 hours before the date of the appointment. **Miranda Wrights Company, LLC.** agrees to waive the fee for any late cancellation, if the undersigned reschedules his or her next appointment within five business days.

Missed Appointments

The appointment fee will be charged for any missed appointments and will not be refunded.

I know of no reasons I/he/she/we should not undertake this counseling and I/he/she/we agree to participate fully and voluntarily.

I have received the Notice of Privacy Practices of the **Miranda Wrights Company, LLC.** and I agree to read it and discuss any questions I may have with my counselor. I understand and agree that this consent form will remain valid subsequent to my reading the notice unless I advise otherwise.

Signature: _____ Date: _____

(Of client or person authorized to consent for client)