I.

FACE SHEET

Today's Date_____

Please Print Clearly THIS SHEET MUST BE FILLED IN COMPLETELY Readmit: _ Yes _ No

First Name _____ Last Name _____ MI_____

Date of Birth _____ Age _____ Race _____

Address _____City _____State_____ Zip _____

Home Phone (__)_____ Work Phone (___) _____ Cell Phone (___) _____

Name of Spouse/Guardian_____

Home Phone (___)_____Work Phone (___) _____ Cell Phone (___) _____

******If the client is under eighteen or is insured under their parent/guardian's insurance, please fill out the parent/responsible party information. If not, please go directly to the insurance information section.***

PARENT or RESPONSIBLE PARTY

Name:_____ Date of Birth _____/_____/_____

Relationship to person receiving services: _____

Address (if different from above) _____
City _____ State_____ Zip _____

Home Phone (___)_____Work Phone (___) _____Cell Phone (___) _____

Email_____

Signature of Person Responsible for Payment _____
(Must be signed for services to begin)

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____
Phone_____ Phone_____
Contract/ID# _____ Contract/ID# _____
Group/Acct#_____ Group/Acct# _____
Subscriber_____ Subscriber _____
Subscriber Date of Birth_____ Subscriber Date of Birth_____

Client's relationship to Subscriber
___Self ___Spouse ___Child ___Other__

Client's relationship to Subscriber
___Self ___Spouse ___Child __Other_____

II. Client Acknowledgment & Consent

By signing below, I acknowledge and agree to the following:

1. **Consent to Treatment:** I voluntarily consent to participate in counseling services with J Group Counseling Services. I understand that I may terminate treatment at any time.
2. **Confidentiality & Limits:** I have received, read, and understand the Notice of Privacy Practices (HIPAA) and the limits of confidentiality (e.g., duty to warn, child/elder abuse reporting).
3. **Cancellation Policy:** I understand and agree to adhere to the 24-hour cancellation policy and that I may be responsible for a **fee of $25** if I miss or cancel an appointment late.
4. **Acknowledgment of Documents:** I confirm that I have received a copy of the following documents:
    - Notice of Privacy Practices **(Initial: ___)**
    - Informed Consent for Treatment **(Initial: ___)**
    - Financial Agreement & Fee Schedule **(Initial: ___)**

III. Terms and Conditions of Mental Health Outpatient Therapy

I. The Therapeutic Relationship

- **Voluntary Participation:** Your participation in therapy is **voluntary**. You have the right to accept or refuse any treatment suggestions and to terminate therapy at any time without penalty.
- **Professional Boundaries:** The relationship is strictly professional. Your clinician will not engage in social relationships, dual relationships, or financial dealings outside of scheduled fee payment with you.
- **Time Commitment:** Therapy involves a commitment of time and energy. Consistency in attendance is vital for progress. The usual session length is **45-50 minutes** for individual therapy.

II. Scheduling, Cancellations, and Fees

- **Appointment Management:** Clients are responsible for keeping track of their scheduled appointments. The office will provide courtesy reminders, but failure to receive a reminder does not exempt the client from the cancellation policy.
- **Cancellation Policy:** A minimum of **24 hours' notice** is required for any cancellation or rescheduling.
- **Late/Missed Appointments:** Sessions missed or canceled with less than 24 hours' notice will incur a **$30 late cancellation/no-show fee**, which is the sole responsibility of the client and is **not covered by insurance**.

- **Late Arrival:** If you arrive late, the session will still end at the scheduled time, and you will be charged the full session fee.

IV. Crisis and Emergency Procedures

- **Non-Emergency Setting:** J Group Counseling Services is an **outpatient setting** and is not equipped to handle acute psychiatric emergencies 24/7.
- **Crisis Protocol:** If you are experiencing a life-threatening mental health emergency (e.g., thoughts of immediate self-harm or harm to others):
    - **Do not wait** for your therapist to return your call.
    - **Call 911 immediately.**
    - Go to the nearest **Emergency Room**.
    - Call the **National Crisis and Suicide Lifeline** by dialing **988**.
- **After-Hours Contact:** For non-life-threatening clinical concerns, you may leave a confidential voicemail or email. The clinician will return your message during regular business hours (typically within 24-48 hours).

V. Communication and Documentation

- **Electronic Communication:** Email and text messaging are used primarily for scheduling and administrative tasks. **Do not use email or text for urgent clinical issues.** Email is not a fully secure method of communication, and confidentiality cannot be guaranteed.
- **Documentation:** Your clinician will maintain professional records of your treatment, including intake forms, session notes, and any relevant assessments. These records are maintained according to state and federal law (HIPAA).
- **Subpoenas and Court:** If your therapist is required to testify or provide records in a legal proceeding, you may be responsible for the professional time involved, including preparation, travel, and court time, billed at the therapist's hourly rate (**$$125$/hour**).

Client Agreement and Signature

I acknowledge that I have read, understand, and agree to the Terms and Conditions of Mental Health Outpatient Therapy set forth by J Group Counseling Services.

Client Name (Printed): _____

Client Signature: _____ **Date:** _____