



## CLIENT REGISTRATION

Client Name(s): \_\_\_\_\_ Today's Date: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Permission to leave message? Circle Y/N      Text? Y/N      Permission to leave message? Circle Y/N      Text? Y/N

Email Address: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Single: \_\_\_\_\_ First Marriage: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_ Remarried: \_\_\_\_\_

Children's names and ages: \_\_\_\_\_

Client's Occupation and Employer: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_ Church: \_\_\_\_\_

Physician: \_\_\_\_\_ Referred By: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### INFORMED CONSENT FOR COUNSELING SERVICES

**Services & Staff:** I understand that Morgan Counseling Services is a private practice offering a wide range of counseling services, and that these services are provided by Licensed Professional Counselors and Provisionally Licensed Professional Counselors. Trainees are supervised by a Licensed Professional Counselor. I have voluntarily sought the therapy/counseling services of: \_\_\_\_\_.

**Confidentiality:** I understand that all information I disclose within sessions is confidential and not to be revealed to anyone outside Morgan Counseling Services without my permission. The only exceptions include, but are not limited to, situations where:

1. there is alleged or suspected child abuse or neglect
2. there is evidence of danger to an individual or society
3. the counselor is subpoenaed and ordered by a judge to testify in a court of law, or as required by law
4. a legal parent or guardian of an individual under the age of 18 requests information about the child
5. for the purpose of providing the best service possible, your case may be discussed with my supervisor and/or peer supervision group, without revealing any identifying information

In the above situations, when possible, my therapist will thoroughly discuss this situation with me and obtain my consent to release information before any action takes place. In an effort to provide quality care, my therapist may confidentially consult with appropriate professional colleagues to seek greater wisdom to provide the best possible counsel.

**Email:** With respect to electronic mail (email), I am cautioned that email is not a confidential means of communication. Furthermore, MCS cannot ensure that email messages will be received. Therefore, I will use email at my own risk and call MCS at 314.221.3773 when I have urgent needs.

**Audio & Video taping:** I understand that my interviews may be audio or video recorded for the purpose of staff training and clinical supervision. The tapes will be treated confidentially and erased after they are used. Any concerns I have about taping will be addressed by my counselor. I will never be taped without my permission.

**Risks & Benefits:** I understand there is a possibility of risks and benefits which may occur in counseling. Counseling may involve the risk of remembering unpleasant events or arousing strong emotional feelings. Counseling can impact relationships with significant others. The benefits of counseling may be improved ability to relate with others, a clearer understanding of self, increased academic/job performance, and better ability to cope with daily stressors. Taking responsibility for working with these issues may lead to greater growth.

**Appointments:** Individual sessions are 45-50 minutes long. If the therapist is late to an appointment, the complete time will be allowed. However, if the client is late, the appointment will end at the scheduled time. It is usually recommended that session begin weekly, however, we will schedule appointments according to your specific needs.

**Calls & Emergencies:** Calls to 314.221.3773 are generally answered by voicemail. During business hours messages are picked up frequently, usually on the hour. After hours, clients with emergencies are encouraged to call Life Crisis at 314.647.4357, Behavioral Health Response at 314.469.6644, or go to the nearest emergency room.

**Cancellations and No Shows:** Our policy requires that an appointment be cancelled 24 hours in advance. If a client does not show for a scheduled appointment or fails to provide 24 hour notice for a cancellation, they will be charged the full fee of the session.

**Payment:** I agree to pay \$\_\_\_\_\_ for each session and agree to inform my therapist as soon as possible of any change in my insurance or finances. I understand I will receive at least 30 days notice before any fee increase. I understand a 24 hour notice is required when canceling appointments and I agree to pay the full fee for any appointment I do not cancel within 24 hours. There is a \$25 service charge for all returned checks.

**Termination:** If after a period of time it becomes clear that I am not benefiting from counseling, my therapist will provide me with one or more referral that may better fit my needs. I understand that I am free to leave counseling at any time. If I choose to terminate counseling prior to the expected termination date, I commit to discuss this decision with my therapist in advance of my actual termination.

I have read the above information and understand what I can expect from counseling. I give my consent to enter in a counseling relationship with: \_\_\_\_\_.

I agree that if any dispute arises with anyone employed by Morgan Counseling Services from or related to this agreement, this dispute shall be settled by mediation, and, if necessary, legally binding arbitration by a professional Christian conciliator.

\_\_\_\_\_  
Client/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

I HAVE DISCUSSED THIS INFORMATION WITH MY CLIENT