MORGAN Counseling SERVICES LLC

CLIENT REGISTRATION

Client Name: _____ Date:_____

Spouse Name:_____Parent and/or Guardian Name:_____

Home Address: _____City:_____

State:_____ Zip:_____ DOB:_____

Sex:_____ Age:_____ Single: ____ First Marriage: ____ Separated: ____ Divorced: ____ Widowed: ____ Remarried:_____

Children's names and ages:_____

Client's Occupation and Employer:_____

Religious Affiliation: _____ Church: _____

Physician:_____ Referred By:_____
Permission to contact physician? Circle Y/N

Current Medications:_____

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, Provisionally Licensed Professional Counselors, and interns. Trainees are supervised by a Licensed Professional Counselor. I have voluntarily sought the therapy/counseling services of: _____, supervised by _____.

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.

MORGAN Counseling SERVICES LLC

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 45-55 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 sessions begin weekly, however, we will schedule appointments according to your specific needs.

Calls & Emergencies: Calls to 314.221.3773 are often answered by voicemail. During business hours messages are picked up frequently, usually on the hour. After hours, clients with emergencies are encouraged to call 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, that is the agreed upon out of pocket rate or the amount the insurance company would have allowed for that 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 that my insurance company may require detailed diagnostic and treatment information and I consent to the release of all requested information. 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. I understand there is a $25 service charge for all returned checks, and credit card payments will include a $2 processing fee. I direct that a copy of my signature on this form serves as a lifetime authorization.

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