Amy M. Childers Counseling, LLC
Client Information

Client Name: _____ Female___ Male ___
First Middle Initial Last

Address: _____
Street City State Zip

Phone Number(s) to reach you: _____

May I leave a message? Yes ____ No____ May I text? Yes____ No____
*Note, counseling issues cannot be via text or email

Email address: _____

Date of Birth: _____ Age: _____ Marital Status: S M D W SEP

Employer/School: _____

Who referred you here? _____

Emergency Contact: _____ Phone number(s) _____

Current medications:

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FOR MINORS:

Mother's Name_____

Address & Phone _____

Father's Name_____

Address & Phone (if different)_____

If applicable, a copy of the divorce decree page showing who has legal custody is required.

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INSURANCE INFORMATION:

Insurance Name: _____

Member ID Number: _____

Group Number: _____

Name of Person carrying insurance: _____DOB:_____

I have completed the above answers to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ _____
Signature of Client Date

_____ _____
Signature of Therapist Date

Amy M. Childers Counseling, LLC
Office Policies for Counseling Services

A. CONFIDENTIALITY: The therapeutic relationship is based on confidentiality. The therapist will not divulge information about any client without the client's written consent (signed Consent for Release Form) EXCEPT when a client is in imminent danger to self, others, or whose life is in danger by another person(s).

B. PAYMENT: Check, cash, or credit card for co-pays, deductibles, coinsurance and/or entire fee is due at the time of service. A $5.00 charge will be assessed for any credit card payment not made in person. A $30 fee is assessed for returned checks. Self-pay and out of network fee is $130/therapeutic hour. **For secondary insurance claims, payments are expected at time of session and client is responsible for filing the claim.** In cases of divorce, the parent/guardian who brings the minor for services will be responsible for providing payment at the time of service. **It is the client's responsibility to gather information from his/her insurance company regarding deductibles, copays, coinsurance, out-of-pocket expenses and any other insurance plan coverage and/or non coverage PRIOR to session. Ultimately the client is responsible for payment**.

C. SESSION INFORMATION: The first session is an informational gathering session and will include client's history, current situation, coping skills and goals. Sessions last for the therapeutic hour. When a client is not seen for 6 consecutive months, it is understood that the therapeutic relationship is terminated. A Client at any time may restart therapy in which it is understood the client would then be under the therapeutic care of Amy Childers/Amy Childers Counseling LLC.

D. FEES: 1. There is a $130.00 fee for any missed appointment(s) that are **not** due to illness or emergency, unless you call/text the office at 419-283-2732, 24-hours prior to the appointment or unless other arrangements have been made prior to your appointment. A message may be left on the voicemail or texted 24 hrs/day,7 days/week. **2.** There is a minimum $130.00 fee for any correspondence requested by third parties including but not limited to doctors, lawyers, schools, and/or any other institutions.
Your signature below indicates your understanding of above policies and your agreement for payment.

_____ _____
Signature of Client **Date**

_____ _____
Signature of Therapist **Date**

E. INFORMED CONSENT TO RECEIVE MENTAL HEALTH TREATMENT:
I hereby voluntarily consent to, and authorize Amy M. Childers Counseling, LLC to render mental health treatment to myself and/or minor child. I understand that at any time I can withdraw my consent in writing.

_____ _____
Signature of Client **Date**

_____ _____
Signature of Therapist **Date**

F. NOTICE OF PRIVACY PRACTICES:
Amy M. Childers Counseling, LLC utilizes cellular telephone (419.283.2732) and internet communication (amychilders@amylistens.org). Due to the nature of cellular and internet communication, telephone calls and/or texts are subject to the possibility of unintended disclosure. Therefore, calls and/or texts made on cellular phones and correspondence on the internet cannot be considered secure. Amy M. Childers Counseling, LLC will not disclose Protected Health Information on cellular telephones or internet. I understand that cellular and email communication to this number/email may not be secure. I also understand that no therapy can take place via text or email.

_____ _____
Client Signature **Date**

_____ _____
Amy M. Childers Counseling LLC, Member **Date**