COUPLES COUNSELING INFORMATION FORM

Today's Date:_____

#1

Name: First_____ **MI**_____ **Last**_____ **Nickname:**_____

Date of Birth: _____/_____/_____ **Gender:**_____ **Sex Assigned at Birth:**_____ **Pronouns:**_____

Address: _____ **Apartment/Unit #:**_____

City:_____ **State:**_____ **Zip:** _____

Email:_____ **OK to Email? Yes___ No___**

Cell #:_____**Home #:**_____ **Work #:** _____

Relationship: Married___ Single___ Divorced___ Domestic Partner___ Widow/er ___ Other_____

Employer:_____ **Fulltime___ Part-time___ Retired___ Disabled___**

#2

Name: First_____ **MI**_____ **Last**_____ **Nickname:**_____

Date of Birth: _____/_____/_____ **Gender:**_____ **Sex Assigned at Birth:**_____ **Pronouns:**_____

Address: _____ **Apartment/Unit #:**_____

City:_____ **State:**_____ **Zip:** _____

Email:_____ **OK to Email? Yes___ No___**

Cell #:_____**Home #:**_____ **Work #:** _____

Relationship: Married___ Single___ Divorced___ Domestic Partner___ Widow/er ___ Other_____

Employer:_____ **Fulltime___ Part-time___ Retired___ Disabled___**

Referral Source to Counseling Associates of Central Iowa, PC: _____

Appointment reminder texts will be sent to: #1_____ #2_____

EMERGENCY CONTACT: We volunteer to provide the below contact information and authorize Counseling Associates of Central Iowa, PC to contact any listed individual on our behalf in the event of an emergency.

Name: _____ Relationship to #1 and/or #2: _____

Address: _____ City:_____ State:____ Zip:_____

Phone (Include area code): _____ Email:_____

INFORMED CONSENT TO TREATMENT/ PATIENT RIGHTS & RESPONSIBILITIES/NOTICE OF PRIVACY

INFORMED CONSENT TO TREATMENT: This form documents that we give our consent to Counseling Associates of Central Iowa, PC, (the "therapist") to provide psychotherapeutic treatment to us.

PATIENT RIGHTS & RESPONSIBILITIES: While we expect benefits from this treatment, we fully understand that no specific outcome can be guaranteed. We understand that we are free to discontinue treatment at any time, but it would be best to discuss it with the therapist before doing so. Our discussion about therapy has included the therapist's evaluation and diagnostic formulation of our problems, the method of treatment, goals, length of treatment, and information about our financial obligation. We have been informed about, and understand, the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. We understand that therapy can sometimes cause upsetting feelings to emerge and may feel temporarily worse before feeling better. We have the right to considerate, safe, and respectful care without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. We understand that we have a right to ask the therapist about the therapist's training and qualifications and where to file complaints about the therapist's professional conduct if needed.

We have fully discussed with the therapist what is involved in psychotherapy and understand and agree to the policies about scheduling, fees and missed appointments. We understand that we are fully, financially responsible for treatment.

In the event of a medical, behavioral, or mental health emergency, or if we cannot keep ourselves safe, we will call 911, go to the nearest hospital emergency room, or call 988 Suicide Hotline. We understand that the therapist cannot provide immediate emergency services. It is our responsibility to take care of ourselves until such a time that we can talk to our therapist.

NOTICE OF PRIVACY: We have received a HIPAA Notice of Privacy Practices from the therapist, or we can obtain a copy from the office. We understand that information about psychotherapy is almost always kept confidential by the therapist and not revealed to others unless we give our consent. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Some exceptions include, but are not limited to, the following:

1. Mandatory Reporting of child/dependent adult abuse or neglect to the proper authorities.
2. Emergency circumstances for the purposes of treating a medical or mental condition which poses a threat to the safety and health of us, any individual, or the public that requires immediate intervention.
3. Judicial and Administrative Proceedings: If we are involved in certain court proceedings, the therapist may be required, by law or otherwise, to reveal information about our treatment.
4. Treatment Purposes: The therapist may consult with other therapists about our treatment but in doing so, they will not reveal our names or other information that would identify us unless specific consent to do so is obtained.
5. When the therapist is away or unavailable, another therapist might answer calls and will need to have access to information about our treatment. We understand that the covering therapist will discuss our situation with us or notify us before any confidential information is revealed and will reveal only the least amount of information that is necessary.

By signing below, we confirm we have read and consent to the above, and we give our consent to treatment.

#1 Signature:_____ Date:_____

#2 Signature:_____ Date:_____

PAYMENT & CANCELLATION POLICY

- **Private Pay: We agree to pay at every appointment the current private-pay fee.**

Payment: Payment is due at the time services are rendered. Cash, check, or credit card is expected at the time of service. Credit Card Agreement forms are available to keep your credit card on file. For all returned checks, there will be a surcharge of $30.00. If termination or withdrawal of service is due to your non-payment, your therapist will work with you to identify other service options. Please let the office staff know before your appointment if a problem arises regarding your ability to make payment.

Missed/Cancelled Appointments: Missed and cancelled appointments pose some issues for both you and your therapist. The work of psychotherapy is sometimes challenging, and you may find it easier to avoid coming in for treatment. It is always better to speak about this with your therapist. We hold your scheduled appointment specifically for you. Your therapist sees a limited number of patients so that you get the focus and attention you deserve. Counseling Associates of Central Iowa, PC may charge you a fee for appointments that are missed and cancelled without 24-hour notice. If you are running late for your appointment, please phone the office as soon as you can to let us know. If you are late for your appointment, it will still end at the regularly scheduled time and the fee will remain the same. We offer text reminders for appointments but sometimes they do not get sent due to various situations beyond our control. We suggest also keeping a written reminder of your appointments to avoid a late cancel or no-show fee.

#1 Signature:_____ Date:_____

#2 Signature:_____ Date:_____

ELECTRONIC COMMUNICATIONS

Counseling Associates of Central Iowa, PC will communicate with you via texts, voicemail messages, and emails. Please let us know if you want to opt-out of receiving appointment reminder texts, leaving messages on your voicemail, and/or messaging through email.

MANDATORY REPORTER POLICY

It is your therapist's duty, as a mandatory reporter, to immediately report any suspected child abuse and any suspected dependent adult abuse to the Department of Human Services (DHS). Your therapist will report suspected abuse orally to the DHS followed by a written report within 48 hours after such oral report. They will also make an oral report to an appropriate law enforcement agency if immediate protection of the child or adult is advisable.

Types of Abuse:

- Physical Abuse
- Mental Injury
- Sexual Abuse
- Denial of critical care.
- Child Prostitution
- Presence of illegal drugs in the body.
- Manufacture or possession of dangerous substances in the presence of the child.
- Bestiality in the presence of a minor.
- Cohabitation with a registered sex offender.

The records are available to both parties and cannot be released to any other individual without written consent that is signed by both parties. However, certain information may be released without your authorization under the following circumstance:

- When Juvenile Court is involved, records may be shared with Juvenile Court Officers.
- Information about a child may be shared with the child's Guardian Ad Litem.
- Information may be shared in the event of a legitimate subpoena for court appearance.
- In the event of a medical emergency.
- When the receipt of information suggests that child or dependent adult abuse or neglect has occurred.
- Auditors may review your records to evaluate treatment effectiveness.

Counseling Associates of Central Iowa, PC is legally obligated to report any such information to DHS when there exists a danger to a child, dependent adult, or others.

This policy has been explained to me in my own language.

#1 Signature:_____ Date:_____

#2 Signature:_____ Date:_____

CREDIT CARD AGREEMENT

We authorize Counseling Associates of Central Iowa, PC (CACI) to charge our credit/debit card for balances due at CACI including no-show and late cancellation fees.

This authorization will be terminated when we stop receiving services and all services have been paid for in full and any overpayments refunded to me. This authorization will be void when this credit card expires; a new form will need to be completed with our new credit card information.

#1 Signature:_____ Date:_____

#2 Signature:_____ Date:_____

____MasterCard ____Visa ____Discover ____American Express

Name on Card:_____

Card #:_____

Expiration Date:_____ Security Code:_____

Your credit card information is securely protected in our HIPAA compliant practice management system with a secure network server. Receipts for any payments can be obtained by calling our office.