Counseling of Alexandria

Consent to Treatment

I/we, the undersigned, give my consent and authorize Counseling of Alexandria, LLC, to provide psychotherapy services. I/we, understand that these services may include individual and family clinical interviews, assessments, consultations and treatments. Services may also include discussions with other individuals in my life by my therapist, but I/we, understand that she will contact no individual without my/our, prior written consent.

I/we, understand that I/we, have the right to refuse treatment or terminate counseling services should I/we, choose.

Signature	Name (please print)	Date
Signature	Name (please print)	Date

Counseling of Alexandria

Confidentiality

Confidentiality is a high value and every effort is made to ensure that client information is kept confidential. However, the state of Virginia and the National Association of Social Workers specify certain conditions in which it may be necessary for information about a client's treatment be discussed with other professionals. The situations in which confidentiality is to be broken are:

- If a therapist believes there is imminent danger that a client may harm him/herself or others.
- If a therapist becomes aware of a client's involvement in abuse of children, elderly or disabled persons.
- If a therapist is ordered by the court to release client records.
- If a client signs an authorization for release form that allows a therapist to discuss a client case with another person; i.e., doctor, psychiatrist, relative.

Signature	Name (please print)	Date
Signature	Name (please print)	Date

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Financial Fee Policy & Agreement

The following is a clarification of the financial/fee policies and agreement. I ask that you read this document and sign your name(s) indicating that you have read, and agree to the following information. Should you have any questions please feel free to discuss them with us.

- Your fee ( ) applies to each forty-five minute individual and/or family session. You are responsible for the fee at the time that services are rendered.
- Counseling services are available outside of your scheduled session when arranged. This time will be billed in five-minute increments and is due at the next session.
- Checks returned due to insufficient funds will incur a charge. This fee replicates the fee the bank sets forth for returned checks, plus the amount the check was written for.
- It is your responsibility to become familiar with and understand your health insurance benefits, including behavioral health insurance benefits, prior to the first session scheduled for you, your child or your family.
- As the time scheduled for your appointment is reserved for you, I ask that you give 48 hours notice, by phone or email, if it is necessary to cancel an appointment. If notice is given in less than 48-hours, you will be charged for that session. Rescheduling of cancelled appointments may be made within the same week of the cancelled session, and only as my schedule allows. All missed visits without cancellation will be charged.
- If you terminate therapy with an outstanding balance of fees you will still be responsible for paying said fees, and if necessary all costs of collection, including attorney's fees.
- From time to time the therapy fees may change. I will notify you in advance if there is a change in the fee schedule.
- A balance carried over 30 days is subject to a late payment fee.
- As guarantee of payment, please complete credit card information below. Your card will not be charged unless you fail to pay an outstanding balance, including but not limited to, a late appointment cancellation.

Name on Credit Card: _____

Billing Address (If different from home):_____

Number_____ Expiration Date:_____CVV Code:_____

I, and/or we, have read, understand, and agree to the above policies.

_____	_____	_____
Signature	Name (please print)	Date
_____	_____	_____
Signature	Name (please print)	Date

Counseling of Alexandria

First Appointment Form

Client Information

Last _____ First _____ M.I. _____ Date of Birth _____

Age: _____ Gender: ☐ Male ☐ Female ☐ _____

Parent/Guardian Full Name (if applicable)

Last _____ First _____ M.I. _____ ☐ Mother ☐ Father ☐ Other Guardian

Last _____ First _____ M.I. _____ ☐ Mother ☐ Father ☐ Other Guardian

Contact Information

Street _____ City _____ State _____ Postal Code _____

Home Phone _____ Mobile Phone _____ Email Address _____

If you would like mobile phone appointment reminders, please list your carrier: _____

Others living in the home:

Name _____ Age _____ Gender: ☐ Male ☐ Female

Name _____ Age _____ Gender: ☐ Male ☐ Female

Name _____ Age _____ Gender: ☐ Male ☐ Female

Health / Medical Information

Primary Care Physician's Name and Phone Number

Do you have any current or past medical issues?

Clinical

Have you received mental health treatment before? If yes, when and what were you treated for?

Misc. Additional comments or important information you would like me to know: