Client Agreement / Contract

This document is designed to ensure that you understand our professional relationship.

At The Center for Growth our desire is to help you meet your goals. To do so, may require one session, several months, or even years of counseling. As a client, you have the right to end your counseling relationship at any point. If counseling is successful, you should feel that you are able to face your immediate challenges.

Although your sessions may be psychologically intimate, it is important for you to realize that your relationship with your therapist is a professional rather than a social one. Please do not invite your therapist to social gatherings, offer gifts, or ask your therapist to relate to you in any way other than in the professional context of your counseling sessions. Your therapist will keep confidential the contents of a counseling, intake, or assessment session. Both verbal and written records about a client can not be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of The Center for Growth not to release any information about a client without a signed release of information.

<u>Limits of Confidentiality</u>

- *Duty to warn and protect:* Your therapist is required by law to contact the police and your family if you disclose intentions and/or a plan to harm yourself or others.
- *Abuse of children and vulnerable adult:* if a client states / suggests that he or she is abusing a child / vulnerable adult, or has recently abused a child or vulnerable adult, or a child / vulnerable adult is in danger of abuse, your therapist is required by law to report this information to the appropriate social service / legal authorities.
- *Prenatal exposure to controlled substances*: As a health care professional, your therapist is required by law to report admitted prenatal exposure to controlled substances that are potentially harmful.
- *In the event of a client's death*: In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's therapy records.
- *Professional misconduct*: Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.
- *Court orders*: Health care professionals are required to release records of clients when a court order has been placed.
- *Minors/Guardianship*: Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.
- *Technology*: The protection of confidential information transferred through telephone and internet are not entirely private. Therapist will utilize best practices to ensure security.

- *Other provisions*:
  1) When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g. diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic.
  2) Information about clients may be disclosed in consultations with other professionals in order to provide the best treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.
  3) When couples or families are receiving services, a joint file is kept. Therapists at the Center for Growth do NOT hold secrets between the people receiving services together. If you wish to keep some things confidential, then you are advised to seek services as an individual, not as a couple or a family. As an individual, you could have your partner (or family) attend some of the sessions. In session, you might notice that the primary difference between individual counseling and couples/family counseling is that the therapist will be focused on meeting your needs, as opposed to the collective needs of the family unit. From a confidentiality perspective, as an individual whose partner sometimes attends session, the partner will not have access to the records, unless a release of information form is signed by you.
  4) In the event that someone from The Center for Growth must telephone you, such as an appointment cancellation, reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by telephone and how you would like us to identify ourselves. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of this organization. If the person answering the phone asks for more identifying information we will say that it is a personal phone call. To protect confidentiality, we will not identify the name of this organization. If we reach an answering machine or voice mail we will follow the same guidelines.

Please check where you may be reached by phone. Include phone numbers and how you would like us to identify ourselves when telephoning you.

___Home Phone Number: _____
How should we identify ourselves? _____
May we mention The Center for Growth _____
___Work Phone Number: _____
How should we identify ourselves? _____
May we mention The Center for Growth _____
___Other Phone Number: _____
How should we identify ourselves? _____
May we mention The Center for Growth _____
___Email Email Address: _____
How should we identify ourselves? _____
May we mention The Center for Growth _____

_____ I authorize the therapist assigned to my case to keep the above contact information with her when out of the office in the event that she needs to call me regarding a scheduling change or some other issue regarding my therapy.

_____ I do NOT authorize the therapist assigned to my case to keep the above contact information with her when out of the office in the event that she needs to call me regarding a scheduling change or some other issue regarding my therapy.

Client Signature: _____ Date _____

Client Signature: _____ Date _____

Therapist Signature: _____ Date _____

Client's Rights and Responsibilities

- Clients have the right to know their therapist's experience and training.
- Clients have the right to know about treatment choices and what their therapist can offer.
- Clients have the right to receive treatment that is helpful to them.
- Clients have the right to receive fair treatment, regardless of race, gender, disability or religion.
- Clients have the right to a safe treatment environment, free from sexual, physical and emotional abuse.
- Clients have the right not to answer any question, or provide information that, for any reason they do not want to provide.
- Clients have the right to refuse audio or video recordings of their session (but you may ask for it if you wish).
- Clients have the right to ask their therapist about their treatment progress.
- Clients have the right to terminate treatment at any point for any reason. If you are court ordered to receive treatment then you still have the right to terminate treatment with your therapist, but there may be legal problems. Thus, it is best if you speak with your lawyer who can advise you further.
- Clients have the right to file a complaint with the government or their therapist's professional group(s).
- Clients have the responsibility to treat their therapist with dignity and respect.
- Clients have the responsibility to give the therapist accurate information so that she can deliver the best care possible.
- Clients have the responsibility to ask questions if they do not understand the therapy process.
- Clients have the responsibility to follow the agreed upon treatment plan.
- Clients have the responsibility to keep their appointments, and if they can't, to call as soon as possible to cancel.
- Clients have the responsibility to openly talk about their concerns with the quality of care they are receiving and to report abuse/fraud.
- Clients are responsible for payment of services received.

Legal Issues

If you are in the midst of any type of legal issues such as litigation, a dispute with your employer, separation or divorce, please inform your therapist immediately. Please be aware that in custody cases, therapists typically need signed permission from both parents, and that medical records are frequently subpoenaed when litigation is involved.

Fee Information & Payment Policy

Your therapist agrees to provide counseling services for you in return for a fee. Each session, otherwise known as a clinical unit, defined as a 53 minute hour for assessment, and individual, family and relationship counseling, will cost _____. My fee for consultation is _____ per 50 minute session. Under most circumstances, it is inappropriate for a psychotherapist to become involved in a treatment client's legal case. However, should this become necessary, the fee for any time your therapist must spend in a forensic situation is _____ per 1 hour unit.

Payment is expected at the time of service. Cash and checks are acceptable for payment. There is a $35 service charge for all returned checks. You will be given a receipt for all fees paid if you would like. Check with your insurance company to determine if your coverage honors outpatient counseling provided by The Center for Growth. Please note that many insurance companies require surveys that request information about symptoms, diagnosis, and treatment. By using your insurance plan you are granting permission for your therapist to communicate personal information to your insurance company. Please remember that The Center for Growth has no control of, or responsibility, for how information is handled once it is released to third parties.

Cancellation / Office Hours

In the event that you will not be able to keep an appointment, you must notify your therapist 48 hours in advance. If such advanced notice is not received, you will be responsible for paying the appointment fee in full. If for any reason you need to contact your therapist, please call (215) 922-5683 and leave a message on her voice mail 24 hours a day, seven days a week. All messages will be returned within 72 hours. Phone messages are checked Mondays through Fridays.

Credit Card Authorization Agreement

Please complete the following information. This form will be securely stored in your (or your child's) clinical file and may be updated upon request at any time.
In the case that you miss or fail to cancel an appointment within 48 hours of the scheduled time you will be charged the full session fee. If a check is returned unpaid you will be charged a $35 fee for the returned check as well as the full session fee.
If I, _____, do not notify my therapist / psychiatrist _____ at The Center For Growth of my/our inability to attend previously scheduled appointments at least 48 hours in advance, I authorize The Center For Growth to charge my credit card. I will only be charged on this credit card in the event that I

fail to show or if I fail to bring my child for a scheduled appointment. Furthermore, I authorize The Center For Growth to charge my credit card for a session if it was paid for by check and the check was returned for any reason. If I have chosen to keep a credit card on file for payment, I authorize The Center For Growth to charge session fees after each appointment. I will not dispute charges ("charge back") for sessions I have received, appointments I missed or did not cancel with 48 hours' notice as described above. I further authorize The Center For Growth to disclose information about my attendance/cancellation to my credit card company if I dispute a charge. By signing below, I acknowledge that I have read, understood and agreed to the terms outlined above. I authorize The Center For Growth to charge fees as described:

Signature: _____ Date: _____

(Patient or responsible party)

Card Type (circle one): VISA, MasterCard. Discover, American Express Other:_____

Card #: _____

Expiration Date: _____ Verification/Security Code: _____

Name on Card: _____

Billing Address: _____

City: _____State: _____ Zip: _____

Emergencies

The Center for Growth is a small organization. Private practice clinicians cannot assume responsibility for client's day to day functioning, as some more intensive treatment programs are designed to do. It is the responsibility of the client to discuss expectations of after-hours care with their therapist upon intake so that, if necessary, an appropriate referral can be made.

Should you feel that your situation requires immediate attention, your therapist will return all calls within 72 hours. You may leave a message on your therapist's voice mail at (215) 922-5683. If you do speak with the therapist, you will be billed at the therapist's current hourly rate for individual therapy for the time she spends with you on the telephone. You should be advised that your insurance company may not reimburse you for the telephone. If you wish to speak with someone immediately and a phone call back from your therapist within 72 hours is not fast enough, please contact your local suicide/crisis hotline. One such number, which is available (24 hours a day /7 days a week) in Philadelphia is (215) 686 – 4420.

In the case of an emergency, when a client fears harm to himself/herself or another, please go to your closest Emergency Room and ask to speak with a psychiatrist.

Local Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Local Hospital: _____

Since my therapist is treating me from a distance, I give my therapist permission to break confidentiality with the above person in the event of an emergency at the discretion of my therapist. Therapist will limit the information shared with the above person and only disclose information to help secure my or others' safety.

As the client, your signature below indicates that you understand the limits of confidentiality and understand their meanings and ramifications and grant consent for The Center for Growth to provide psychological services and counseling to you and /or minor members of your family. Lastly, your signature acknowledges that you have received a copy of this form, including the Client's Rights and Responsibilities and Crisis/Emergency Procedures.

Client Signature _____ Date _____
Client Signature _____ Date _____
Therapist _____ Date_____

To Parents of Teenagers

As the client, your signature below indicates that you understand the need for confidentiality between your teenager and their therapist, and that confidentiality will be maintained unless this therapist determines that your teenager is a danger to self or others.

Parent / Guardian Signature _____ Date _____

Personal Data Inventory

Assessment Date:_____

Please fill out this sheet as thoroughly as possible. All information is confidential and for The Center for Growth, Inc. records only. Note: If you have been a client here before, please fill in only the information that has changed.

Name: _____Nickname:_____
Date of Birth:_____Age:_____ SS#:_____
Race:_____ Gender: _____
Address: _____
City: _____State: _____Zip Code: _____
Home Phone: _____Cell Phone:_____
Work Phone: _____Email:_____
Occupation:_____Education: (Last year completed) _____
Other training: List type and years_____

Referral: How did you find out about the Center for Growth?
Name: _____
Address:_____
Web Site:_____
If you got my name from a person (as opposed to the Internet) may I have your permission to thank this person for the referral? Yes_____ No_____

Briefly state your reason for being here today:_____
_____

_____

What significant life changes or stressful events have you experienced recently:

_____

_____

Health History

Height: _____ Weight: _____

List all important present or past illnesses, injuries or handicaps _____

_____

_____

Date of last medical exam _____

Primary care doctor _____Phone _____

Address _____

Urologist / Gynecologist _____Phone _____

Address _____

If you enter treatment with me for psychological problems, may I tell your primary care doctor and urologist/gynecologist so that he or she can be fully informed and we can coordinate your medical treatment?

Primary Care Doctor: Yes_____ No_____

Urologist: Yes_____ No_____

Gynecologist: Yes_____ No_____

Current Medications

Condition	Medication	Dosage	Frequency	Start Date

Allergies / Reactions to medications: _____

_____

Have you ever received psychological or psychiatric treatment or counseling services before?

Yes_____ No_____ If yes, please indicate

When?	From Whom?	For What?	With What Results?

Safety

How safe do you feel at home? _____
Is there potential for violence or hostile/abusive behavior? _____

Are you currently having thoughts about hurting yourself? Or have you ever had thoughts about harming yourself? _____
_____
Have you ever attempted suicide? _____
_____
_____Have you ever been hospitalized for suicidal ideations? _____
_____
_____
Are you currently having thoughts about hurting others?_____
_____
Have you ever hurt someone else? Please include all childhood fights where someone else might have ended up with a black eye, broken bone, smashed hand etc. _____
_____
_____
Have you ever been hospitalized for homicidal thoughts? _____

Family/Environmental

Sexual Orientation: _____
Single____ Living Together____Married_____Open Relationship_____
Polyamorous_____Separated_____ Divorced_____ Widowed_____
If in a relationship(s) for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

Name of partner(s): _____ Partner(s) age: _____
Relationship to you: Spouse___ Partner___ Friend ___ Other (describe) _____
Address:_____Phone: _____
Occupation: _____

Is your partner willing to come for counseling? Yes _____ No _____Not Sure_____
Have you ever been separated? Yes __No ___ When_____
Have either of you ever filed for divorce? Yes ___ No___ When_____
Date of Marriage_____ Any previous marriages? No ___ Yes____ When_____
List children and ages _____
Religious background
Religious preference? _____
What are your parent's religious preferences? _____
Is faith an important part of your life?_____

In your family, is there any history of a mental health disorder (anorexia, anxiety, bulimia, depression, panic attacks, schizophrenia, sexual addiction, etc) Yes____No____ Suspected_____ Unknown _____. If yes, please indicate.

Diagnosis	Mother	Father	Sibling	Child	Spouse	Uncle Aunt	Grdparent	Other

Have you ever received drug or alcohol treatment / services before? Yes____No___ If yes, please indicate.

When?	From Whom?	For What?	With What Results?

Cigarette Use History

Do you smoke cigarettes currently or in the past? Yes _____ No _____

- If Yes: Present cigarette use: *Number of cigarettes daily* ____ *Duration of use:* ___*Years*

Past cigarette use: *Duration of use* _____ *years*

Legal History

Are you presently suing anyone or thinking of suing anyone? No ____ Yes _____ If yes, please explain _____

_____

Is your reason for coming to see me related to an accident or injury? No ____ Yes _____ If yes, please explain _____

_____

Are you required by a court, the police, or a probation/parole officer to have this appointment? No ____ Yes _____ If yes, please explain: _____

_____

Drug & Alcohol Usage

Substance	Alcohol	Pot	Hallucinogens	Opioids	Cocaine/ Crack	Club Drugs	Pain Medication
Daily Amount Used							
Weekly Amount Used							
Monthly Amount Used							
Weekly Amount of $ Spent							
Do you use when you are alone?							
Have you ever driven under the influence?							
Date of last usage?							
Do you think you have a problem?							