Cartersville Counseling & Therapy
Daryl Gessner, LPC
911 N. Tennessee St, Suite 104, Cartersville, GA 30120
Phone (770) 608-8447
http://www.CartersvilleCounseling.com

CLIENT INTAKE INFORMATION FORM (PLEASE PRINT CLEARLY)

Client's Name: _____ DOB: _____M___F___

Address: _____ Home Phone: _____Y__N__

City/Zip: _____ Work Phone: _____Y__N__

Marital Status: _____ Cell / Pager: _____Y__N__

Email address: _____ Employer/School: _____

Spouse/Partner or
Parent'sName(s):_____DOB:_____

Emergency Contact:_____ Phone:_____

Permission to email: Y__N__ Permission to call/leave message: Y__N__

Permission to text: Y__N__

What is the relationship and ages of the persons who live in the house with you?

_____

_____

Briefly describe the reason(s) for seeking help: _____

_____

_____ _____

Religious/Faith/Spiritual Belief System: _____

Prior Therapy Experience and/or Therapeutic Diagnoses: _____

_____

Primary Care Physician's Name/Date of last Appt.: _____

Allergies: _____

Medical Problems: _____

Medications: _____

_____ _____
Authorized Signature Date

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INFORMED CONSENT AND AUTHORIZATION FOR TREATMENT

PLEASE READ THE FOLLOWING REGARDING TREATMENT POLICIES AND SIGN BELOW:

1. **Confidentiality:** All communications between counselor and client is held in strictest confidence *unless:*
   A. The client authorizes the release of information with a signature and waives this privilege.
   B. The counselor is ordered by a court to release information.
   C. Dependent abuse/neglect is suspected or revealed.
   D. The client appears to pose a direct threat to his/her or someone else's life (ex. actively suicidal or homicidal).

2. **Regarding Children:** Children (under the age of 18) are only seen with signed permission from a parent/caregiver who has legal custody of the child. Parents have a right to any and all confidential information regarding your dependent with the exception of raw test data. Because the presence of trust is important in the therapeutic relationship between your dependent and me, it is generally best that I do not share specifics of individual sessions with you. However, you have the right and responsibility to question and understand the nature of your dependent's treatment plan, and the progress being made toward treatment goals. If your dependent is able to understand the issue of confidentiality, I will discuss with him/her the type of information that will be shared with you. If you have objections to this manner in which information is shared with you regarding your dependent, we will need to resolve these differences before therapy begins.

3. **Court Testimony:** I am not trained in matters that involve the legal system. If required to testify for court, speak with legal counsel, etc. my fee is $150 an hour plus mileage and expenses incurred. *I will not testify in divorce custody or mediation*. **A 3-hour minimum charge will need to be paid before any meeting or court date. Additional charges will be accrued and later charged to the client if the event goes on for longer than three hours.**

4. **Case Consultation:** I occasionally consult with colleagues regarding cases in order to provide clients with the best possible care; in these situations, I do not disclose client names or other identifying information.

5. **Digital Policy:** Individuals may contact their respective therapist using technological resources. In doing so, they agree to the understanding that phone calls, text messages, email, and fax communications are not guaranteed confidential methods of communication. When used, the client is, by choice, ***relinquishing their rights to confidentiality***. Please be mindful that should you send an email to your therapist, we will review your email at the beginning of the next session. Texting is allowed for scheduling or rescheduling appointments.

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6. **Psychotherapy Treatment:** Clients may experience possible side effects when experiencing psychotherapy. These risks may include recalling unpleasant events, facing unpleasant thoughts or beliefs, increased awareness of feelings and/or alteration of your ability or desire to deal effectively with others in a relationship. If any of these situations occur, the counselor will work with the client to deal with the potentially negative side effects of our work together.

   Note: In couples and family therapy, no secrets will be kept among those actively participating in the therapy.

7. **Termination of therapy:** Termination of therapy may occur at any time and may be initiated by the client or the therapist. In either event, a final termination session is strongly recommended to explore the termination process itself. This can provide a constructive and useful conclusion to treatment. Referrals or other suggestions will be offered at that time.

IF YOU HAVE ANY QUESTIONS, PLEASE LET US KNOW.

I have read and understand the conditions as stated above. By signing below, I authorize my therapist to begin therapeutic treatment at this time.

Client Signature: _____Date: _____

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1. **Fees, Charges, and Responsibility for Payment:** Sessions are 50 minutes in length. The fee is $150 a session hour; please pay in full by cash or debit/credit card before each session begins.

    a. Visa and MasterCard are accepted, as well as Healthcare Spending Account debit cards.

    b. If in extenuating circumstances a check is taken, a fee of $35 plus additional expenses incurred will be applied if your check is returned for insufficient funds. Additionally, you will be responsible for any expenses incurred to collect any unresolved balances.

    c. **You will be responsible for the full fee payment if less than 24 hours' notice is given. If the session is rescheduled within the same week that the original missed date occurred, then the cancellation fee will be waived.**

2. **Contact Procedures:** Sessions are scheduled directly with your therapist. You are required to give at least **24-hour notice** in advance if you are unable to keep a scheduled appointment. If you leave a voicemail, email or text, it must also be done at least **24 hours** in advance to avoid the fee from being billed.

3. **Report Fee:** Forms, Letters and Affidavits will incur a $35 per report fee.

4. **Unresolved Fee Balances:** The client agrees to allow Cartersville Counseling & Therapy and its therapists to submit any unresolved fee balances to a collection agency for the purpose of collecting any outstanding debts. Part of the submission process will include disclosing the name of the client and the nature of the debt.

I have read and understand the conditions as stated above. By signing below, I authorize my therapist to begin therapeutic treatment at this time.

Client Signature: _____Date:_____