

Sanctuary Counseling, LLC
The Practice of Vivien Morrison, LMHC
Counseling Agreement

The following is an agreement between Sanctuary Counseling, LLC and:

Name: _____ DOB _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Cell: _____

Email: _____ OK to leave messages? _____

How did you hear about my practice? _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Appointment Agreements:

1. Counseling sessions are scheduled for 50 minutes. If session extends beyond 60 minutes, I understand I will be charged appropriately.
2. I am responsible for showing up for counseling at the pre-appointed time. I understand if I am late I may not be able to have a full session but will be charged for such.
3. I understand that my session fee will be charged the morning of the scheduled appointment and that if the method of payment on file is

declined, I will be asked to provide another method of payment before session can begin.

4. **I agree to give a 24-hour notice for cancellation. If I provide less than a 24hour notice or fail to show up for my appointment, I understand that I will be charged the full session price (50 min. = \$100)**

Financial Agreements:

1. I have agreed on the following session rate of **\$ 100** per session.
2. I understand that monies paid in advance are non-refundable.
3. Payment is required before or at the time services are rendered. If payment is not received before or at the time of service, I understand that no further sessions can be scheduled or honored until payment is made in full.
4. Payment options include: Cash, Credit Card (MC, Visa, Amex)

Credit Card Information:

In order for counselor to collect cancellation and no-show fees as appropriate, credit card information will be recorded below. I authorize Sanctuary Counseling, LLC to charge this credit card cancellation and no-show fees (see above) as appropriate. This credit card will also be used for all fees that have not been paid within 30 days. I will be provided a receipt for all payments upon request. I understand that I may revoke this agreement at any time by providing a request in writing.

Visa Amex Master Card

Name on Card _____

Card # _____

Exp Date _____ Billing Zip Code _____ Security Code _____

Signature _____

Confidentiality:

I understand that I have a right to privacy. In other words, what is said in session with my counselor will not be revealed to others. There are exceptions to this confidentiality by law:

1. I sign a written release of information, therefore, waiving my right to privacy and providing Sanctuary Counseling, LLC permission to disclose information to the person or institution I specify.
2. In the event that my counselor receives a court order to release information about me. I will be notified that the requested information will be released.
3. My counselor feels that I pose a danger to myself or others. This may include but is not limited to: high risk of suicide, perpetrator of abuse or neglect of a child or elderly person, or homicidal plans.

Discharge: I understand that I will be administratively discharged if more than 60 days has elapsed since my last session.

Liability Release:

I, _____, take full responsibility for my choices and behaviors during and as a result of counseling. I release my counselor from any financial, legal, physical or psychological impact that results from my participation in counseling as well as any claim for failure on my part to produce the results I intended.

I have read, understood and accept the terms of this contract.

Signature of Client

Date

Personal History Information:

Chief Complaint or issues you are concerned with:

List any major health problems for which you currently receive treatment:

From whom or where do you get your medical care?

Name: _____

Address: _____

Phone: _____

If you enter treatment with me, may I tell your Medical Doctor so that he/she can be fully informed and we can coordinate treatment? Y/N List all medications you are currently taking:

Have you ever received psychiatric help or counseling of any kind before? Y/N

What was the result? _____

Identification of Symptoms:

Please circle any of the following problems that you are experiencing currently.

- | | | |
|-----------------------|--------------------|----------------------|
| Nervousness | Isolating | School Problems |
| Shyness | Sexual Problems | Suicidal Thoughts |
| Separation | Divorce | Financial Difficulty |
| Anxiety | Drug Use | Alcohol Use |
| Aggression | Friends | Anger |
| Depression | Self Control | Unhappiness |
| Fears | Sleep Difficulties | Stress |
| Distractibility | Work | Relaxation |
| Panic/Anxiety Attacks | Headaches | Fatigue |
| Weight Issues | Legal Matters | Memory |
| Eating Problems | Ambition | Lack of Energy |
| Grieving | Insomnia | Making Decisions |
| Childhood Issues | Loneliness | Inferiority Feelings |
| Impulsiveness | Concentration | Education |
| Infidelity | Career Choices | Health Problems |
| Mood Swings | Temper | Nightmares |
| Motivation | Marital Problems | Children |
| Self Esteem | Appetite | Being a Parent |
| Troubling Thoughts | Stress Management | |

Other Concerns or Issues: