Life Connections Counseling, LLC

Nichole H. Aiken, LPC, CSAT, CPTT Candidate

Informed Consent for Treatment

How were you referred to Life Connections Counseling, LLC?

_____

NOTE: If you are seeing Nichole at Life Connections Counseling, LLC for couple's therapy, each person must fill out and bring a separate set of forms to your first couple's session.

Welcome

Welcome to Life Connections Counseling. I am Nichole Aiken, LPC, in the Commonwealth of VA, and I look forward to supporting you on your healing journey. These forms contain information about Life Connections Counseling, LLC's professional counseling services and business policies. It is important that you review the following information before beginning your first session. Please feel free to ask any questions you may have about these policies. I am happy to discuss. Please bring these completed forms with you to your first session.

Therapy Services – Risks and Benefits

The role of a therapist is to assist clients with issues regarding relationships, addictions, and issues such as depression, anxiety, grief, and other challenges that impact you emotionally. Counseling often involves discussing difficult aspects of your life. During our work together you may experience uncomfortable feelings such as sadness, guilt, shame, anger, or frustration. As a result of what comes out of your therapeutic work and the decisions you make, important relationships may be impacted or may end. Your journey in therapy may also lead to healthier relationships. Counseling support often helps an individual find solutions to problems with family and friends, life challenges, as well as a reduction in feelings of distress, anxiety and depression. If you ever have any concerns about your therapy process, we encourage you to discuss this with your therapist during your sessions so that we can collaborate together as you move forward.

My credentials include the following:

- **B.A. Psychology- George Mason University, Fairfax, VA**
- **M.Ed. Community Agency Counseling, George Mason University**

I have also attended post-graduate training and numerous professional trainings to offer you the best treatment possible in my field of expertise. I am a Certified Sex Addiction Therapist (CSAT)credentialed by the International Institute for Trauma and Addiction Professionals (IITAP). I have

- **I am in the process of completing the Certified Partner Trauma Therapist (CPTT).**
- **I am trained in trauma resolution, Brain spotting.**

Termination of Therapy

You may terminate therapy at any point. When our work comes to a close, we ask that you schedule at least one final session in order to review the work you have done. Occasionally clients return to therapy to process new challenges. If you decide to return in the future, please know that Life Connections Counseling, LLC has an open-door policy and welcomes the possibility of working together again.

Length of Therapy

Therapy is a process that is unique to each client and the challenges they are presenting with. Some presenting issues can be worked on very effectively in a fairly short period of time (10-20 sessions). Other challenges may take much longer. It can be difficult to predict exactly how long therapy will last and this is best discussed in your first session. You and your therapist will put together a treatment plan and goals that you will be working toward. A guideline to remember is if you attend forty 50-minute therapy sessions that is less than an average work week. If you have questions regarding the length of treatment, please feel free to discuss this with your therapist at the start and/or at any point during therapy.

Dual Therapy

It is unethical for two different therapists to provide counseling for the same client at the same time. Unless there is a compelling clinical reason, a crisis, or a specialized therapy treatment plan that we will be working on, the therapists at Life Connections Counseling, LLC do not work with clients who are under the care of another therapist. If you are working with another therapist, please disclose this so that we can discuss next steps. If your therapist has referred you to Life Connections Counseling, LLC for specialized treatment (i.e. sex addiction recovery for example), we will need to have a release on file from you in order to coordinate care with your primary therapist and collaborate on a clinical plan that best supports your process.

Legal Exceptions to Confidentiality

Your information is confidential, but there are exceptions. These include: information relating to child abuse (physical, sexual, emotional, neglect), suspected child abuse, elder abuse or neglect, dependent adult abuse, intent to harm self or others, or threats to damage another person's property. Legally, therapists are mandated reporters of abuse or intent to harm another. If you are suicidal or homicidal, I will take all reasonable steps to prevent harm to you or someone else. Legal exceptions to confidentiality are in place to protect your safety and the safety of others. If you are homicidal and make a serious threat to hurt another person, I will contact 911 and make every attempt to warn the intended victim or victims. In addition to these exceptions, if a court issues an order to release records (for example, a divorce hearing or custody hearing), I must abide by the court order and may be compelled to testify under oath, and thus, must answer all questions honestly.

Suicide Policy

If you are suicidal, your therapist will take all reasonable steps to prevent harm to yourself. This may include breaking confidentiality if you pose a serious risk of self-harm to yourself. Your signature indicates that you have read and understand confidentiality and limits to confidentiality:

Client's signature:_____ **Date:**_____

Emergency Contact Information

In the event of an emergency, please provide a contact person:

Name:_____

Relationship:_____ **Phone**_____

No Secrets Policy

Please note that with couples and family therapy the couple and/or the family is the client (e.g. the treatment unit), **not the individuals**. As such all therapists at Life Connections Counseling, LLC practice a **no-secrets policy** when conducting marital/couples/family therapy. This means that confidentiality does not apply between the couple or among family members when one member of the treatment unit requests an individual session or contacts their Life Connections Counseling, LLC therapist outside of the therapy session to share a secret. On occasion an individual session may be scheduled to assist in the overall therapy process to the treatment unit (e.g. the couple) and will be scheduled only when mutually agreed upon. Please understand that any information given in the individual sessions **will not** be held in confidence or secret in couples and/or family sessions.

Your therapist will encourage the person holding the secret to share the secret in the following session and will support the client in doing so. Your therapist also reserves the right to share or disclose information revealed by one partner or family member in an individual session to the other partner or family members as deemed appropriate or necessary to support the treatment unit's overall treatment progress and goals. If you are seeking couples therapy, or family therapy, please have each member of the treatment unit fill out and sign an intake form.

Sobriety Policy

We ask that all clients, couples, families, and group members arrive to therapy sober and not under the influence of drugs and/or alcohol. If your therapist notices that you are intoxicated (such as slurred speech, rapid speech, smelling of alcohol, behavior that indicates intoxication with cocaine, prescription drug abuse, marijuana, or other substances) the therapy session will be immediately terminated. We will also assist you in finding a safe ride home (via friend, family member or taxi) as driving while under the influence constitutes a risk to others and is a reportable offense. Once you are safely home, your therapist will reschedule the therapy session where this occurrence will be processed. **You will be charged your full fee for the session if you arrive intoxicated.**

Therapy Sessions

Therapy sessions are typically weekly, and are scheduled in advance. Standard sessions are fifty minutes in length. Longer sessions are available by request and upon availability of my schedule at a prorated fee. Sessions are conducted in my office. If you are unable to attend sessions in person, they may be conducted via videoconference. The fee is the same for each method, as the same amount of time must be blocked out for any therapy session. It is understandable that occasionally you may be late. If you are late to your session, please understand that the session will not extend past your fifty minutes, nor will the time be made up at future sessions, as this will impact other clients. Intake appointments and Brainspotting sessions will be 90 minutes in length.

Therapeutic Approach & Style

My style is honest, challenging, collaborative, and direct, with solid boundaries and empathy. I will reflect, assist, encourage, and point out incongruent patterns around your actions and words. I will not work harder than you do, nor will I accept responsibility for your choices or consequences. I respect my clients' decisions, and do not often advise or direct my clients, as I believe that you are the expert in your own life and are fully capable of creating the life that you want with support and tools. While I will meet you each step of the way in your therapy process with expertise, accountability, compassion, and empathy, a therapist is not a cure-all, a parent, a friend, or a miracle worker. I will formulate a therapeutic plan collaboratively with you, based on your needs, presenting problems, and the goals you wish to achieve. Because I believe each client bears the responsibility for their choices and meeting their therapy goals, I do not make guarantees for healing. I use a combination of cognitive behavioral, existential, EMDR, and Daring Way™ therapy with most clients.

Cognitive Behavioral Therapy (CBT)

Stresses the role of thinking patterns in how we feel and what we do. It is based on the belief that our thoughts, rather than people or outside events, cause our negative feelings. During CBT, we will work to find the source of negative thinking, and transform those thoughts into a positive, growth-oriented mindset. The ultimate goal of CBT is to replace negative thoughts and actions with productive behaviors that equip you to overcome any difficult moment. As your therapist, I will then help you to modify those thoughts and the behaviors that flow from them. CBT is a structured collaboration between therapist and client, and often calls for homework assignments.

Existential psychotherapy is based on the philosophical belief that human beings are fully equipped to create their own meaning and exercise their freedom to choose. As an existential therapist, I encourage clients to face life's anxieties and to start making their own decisions while reflecting on consequences and moving away from fear-based thinking. I will emphasize that along with having the freedom to carve out meaning comes the need to take full responsibility for the consequences of one's decisions.

Brainspotting-Trauma Work

Brainspotting is a powerful, focused treatment method that works by identifying, processing and releasing core neurophysiological sources of emotional/body pain, trauma, dissociation and a variety of other challenging symptoms. Brainspotting is a simultaneous form of diagnosis and treatment, enhanced with Biolateral sound, which is deep, direct, and powerful yet focused and containing.

Court Reports or Letters The therapists of Life Connections Counseling, LLC do not write legal letters or court reports on behalf of clients involving divorce, custody or other legal matters or lawsuits. We do not write letters pertaining to legal matters to any outside person (i.e. doctor, school, attorney, etc.) or agency regarding your treatment. If a special circumstance arrives where a letter is required by court order, it will require your written consent and will be billed to you at $25.00 per page and in addition to our hourly fee. We reserve the right to refuse to write letters on your behalf (unless court mandated) if we do not feel this would be in your best interest, if it places us in a dual relationship, or will compromise our therapeutic relationship. We will not write letters on your behalf if you are involved in a lawsuit for any aspect of your personal or professional life, as this places us in a dual relationship, or will compromise our therapeutic relationship.

Court Fees:

If you become involved in legal proceedings that require your therapist's mandated participation, you will be expected to pay for all of your therapist's professional time, including preparation and transportation time and costs, even if called to testify by another party. Because of the time involved and the interruption to my clinical work, you will be charged $250 per hour for time out of practice, time for preparation, travel time, and attendance at any legal proceeding on your behalf that you will be responsible for. Additionally, if other client sessions must be cancelled, these must be covered at the rate of those sessions and will be billed to you. Court fees can be very expensive so please sign and date below to indicate that you understand your financial responsibility in covering these expenses should your therapist be mandated to go to court for a legal issue you are involved in. A therapist is not a court advocate or friend. A therapist must legally speak truthfully under oath.

Insurance:

In order for a client to be reimbursed by an insurance company, a diagnosis of the client must be made and submitted to the insurance carrier before the client is reimbursed. Sometimes information about theclient's presenting problem and symptoms is required by the insurance company from private therapy records. This information, once released, becomes part of the client's medical records and may impact confidentiality. Because of this, I do not work with health insurance programs. I am glad to provide a "superbill' receipt that you may submit to your insurance company if you wish for possible out-of-network reimbursement. However, I do not fill out forms or work directly with your health care insurance company. Additionally, it is important that you also understand that there is no guarantee that your insurance carrierwill cover your therapy sessions. I ask that clients carefully consider this before we begin our worktogether. If you choose to work with me, my policy is fee-for-service, as described. I understand Life Connection Counselings insurance policy and agree to it.

Fees

The fee for my individual counseling services is $170 per fifty-minute session. This fee is the same for in office, teletherapy (phone sessions), Zoom/VSEE- Skype Sessions, or couples therapy. Intake appointments (your initial appointment) are $195 and brainspotting sessisons are $195. If you need or want extended sessions for either seventy-five (one and one-half sessions) or one hundred minutes (double session), this fee willbe prorated. Fees are reviewed annually, and may increase periodically. The increase will be discussed with you, and a thirty-day notice will be given prior to the increase. I will be happy to answer any questionsyou may have about this fee agreement.

There are 2 sliding scale fee session spots for each therapist which may be filled at any point in time. If you are not able to afford the fee even if the sliding scale is available, we will not be able to work together, but we will be happy to provide you with three (3) therapy referrals for low cost clinics that offer lower fees. If you utilize the LCC sliding scale, from time to time we will revisit your fee and discuss a possible increase. Should your financial situation improve, your therapist will then discuss an increase in your fee that either meets or is closer to the full fee.

(PLEASE NOTE: Fees are agreed upon per each client's financial consideration and prior to your first session. Disclosing client fees or discussing your client fee among other LCC clients or in a LCC group is an unethical therapeutic practice and is a breach of confidentiality.)

Session Payments

I customarily charge clients for my services on a weekly basis following the time of their session Sessions are paid via Visa, MasterCard, American Express or Discover; debit or credit card. Credit card information is stored securely and is password protected. You may also pay by check. If a check is returned, you will be financially responsible for all bank charges incurred as a result of the returned check. Some clients prefer to pay by cash for privacy. If you choose to do this, please bring the exact cash amount for your session fee, as I do not keep cash at the office. Charges for unpaid services may be turned over to a collection agency, which compromises confidentiality. I do not carry over session payments from week-to-week or extend credit, as this could constitute an unethical “debtor/creditor” dual relationship and ultimately impact our therapeutic relationship.

Weapons Policy:

In order to ensure a safe environment for employees and customers, RelationSkills, LLC prohibits the wearing, transporting, storage, or presence of firearms or other dangerous weapons in my facilities or on my property. A client or visitor who violates this policy may be removed from the property and reported to police authorities. Possession of a valid concealed weapons permit is not an exemption under this policy.

I understand Life Connections Counseling weapons policy and agree to it.

Cancellation Policy

Notification of cancelled appointments, scheduled but not attended, must be made Forty-eight hours prior to the appointment time. If you miss an appointment without notification, you will be charged on the credit or debit card you provide on the intake form. If you have set up a recurring appointment (for example, you are scheduled every other Friday at 11 a.m.) and you miss that appointment and fail to give me forty-eight hours notice, you will be charged for the missed session and automatically rescheduled for the following session at the agreed upon time unless you notify me otherwise. If you miss the second session without notifying me, you will be charged for that session and your recurring appointments will be cancelled unless you contact me and schedule another appointment. In addition, this notification extends to seventy-two hours when applied to an appointment on a Monday. I will need to know by the prior Friday if you will not attend your Monday appointment. You will be sent an email reminder two days prior to your appointment. Please make sure that these reminders are not being sent to your spam folder. You are responsible for keeping track of and attending your sessions. Thank you for respecting this clinical boundary, as my professional time for your session has been set aside specifically for you.

Consent for email and text messaging:

I consent to allow Nichole Aiken, LPC and Life Connection Counseling, LLC, to use unsecured email and mobile phone text messaging to transmit to me information related to the scheduling of meetings or other appointments and information related to billing and payment. This authorization is for the period I am in treatment at Life Connection Counseling and for sixty days following my termination of treatment. I have been informed of the risks,including, but not limited to, my confidentiality in treatment, and of transmitting my protected health information by unsecured means. I acknowledge the risks and release Nichole Aiken, LPC and Life Connections Counseling, LLC from liability for the risk to my confidentiality. I understand that I am not required to consent to receive email or text messages in order to receive treatment, and that I may terminate this consent at anytime.

Consent for email appointment reminders: I send clients automated appointment reminder emails through our electronic records keeping system,TherapyNotes. These appointment reminders are sent forty-eight hours prior to your appointment. Appointment reminder emails are subject to the same confidentiality risks as all other emails and texts.

I consent to allow Nichole Aiken, LPC, and Life Connections Counseling, LLC to send me automated appointment reminders by email.

Telephone calls

Sometimes clients need to reach out between sessions. I am happy to provide whatever a few minutes on the phone can help a client with-- holding space, empathy, counsel, or advice. Any telephone conversations that go longer than ten minutes become billable time. If we talk on the telephone for longer than ten minutes, you will be billed in increments of quarter hours at a prorated rate at my fifty minute fee

Policy Regarding Internet, Professional, and/or Social Networking Sites

On the topic of Social Media and Internet Sites, our primary concern is your privacy. If you follow your Life Connections Counseling, LLC therapist on a site like Twitter or Facebook for example, please note that your Life Connections Counseling, LLC therapist will not follow you back. Casual viewing of clients' online content outside of the therapy session can create confusion in regard to whether it is being done as a part of treatment and viewing your online activities without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship.

Email Policy

The staff at Life Connections Counseling, LLC prefer using email only to arrange or modify appointments. Please do not email content related to your therapy sessions, letters to read, blogs, videos, as email is not completely secure or confidential.

Illness Policy

When a private practice therapist is consistently exposed to cold and flu viruses in the office and becomes ill as a result, the office closes down, sessions and groups are cancelled, and everyone suffers. In order to maintain good health and create a safe and relatively germ free environment we ask that clients was are experiencing any stage of illness to respect safety boundaries and to conduct their sessions via telehealth or phone until they are recovered completely. I understand that my therapist may ask that my session be conducted via telehealth or phone if I myself or my therapist is ill or recovering from a contagious flu virus.

Thank you for the referral; We are honored by your trust and confidence.

(Please proceed to the next section and fill out the following information in full.)

New Client Intake

Please enter your information.

First Name:_____Middle Initials:_____ Last Name: _____

Date of Birth: _____

Gender:

☐ Female ☐ Male

Address:_____

Apt./Unit #:_____

Mobile Phone:_____

Home Phone: _____

Work Phone: _____

1. Preferred contact method:

☐ Mobile ☐ Home Phone ☐ Work ☐ Phone Email:

Do we have your permission to contact you via (please check on all that work for you):
☐ Voice mail ☐ Text message ☐ Email

Details, if applicable:

_____
_____
_____
_____

2. Please describe what has led you to seek counseling now. How long has this been a problem for you, and in what ways do your current difficulties affect you?

_____
_____
_____
_____

3. Please describe what has led you to seek counseling now. How long has this been a problem for you, and in what ways do your current difficulties affect you?

_____

_____

_____

_____

4. Have you dealt with any of the following emotional / behavioral problems? Check all that apply.

- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Irritability
- ☐ Pornography use
- ☐ Inappropriate social
- ☐ Sexual behaviors outside your values
- ☐ Chronic lying
- ☐ Extreme worry
- ☐ Impulsivity
- ☐ Violent temper
- ☐ Infidelity
- ☐ Relationship betrayal
- ☐ Sexual difficulties
- ☐ Distrustful
- ☐ Hostile/angry
- ☐ Indecisiveness
- ☐ Self-injurious

If "other(s)", please specify

_____

5. What would you like to gain from counseling now? How would things be different if your difficulties were resolved?

_____

_____

6. What methods have you been using to cope with these problems?

_____

_____

7. What support do you have in your life (family / friends / school / work / pets/ social activities, etc)?

_____

_____

8. Have you received psychotherapy or counseling in the past? If yes, when was this? Please list the mental health care providers' (Counselor / Psychologist / Psychiatrist) names to the best of your recollection.

_____

_____

9. If you have received psychotherapy or counseling in the past, please describe the problems you were having:

_____

_____

10. Which - if any - of these substances do you currently use or have used in the past? Please use the box to indicate your age at first use and age at last use. (E.g.: Alcohol - 16, 30)

☐ Alcohol _____	☐ Caffeine _____	☐ Hallucinogens (e.g., LSD) _____	☐Nicotine/tobacco
☐ Amphetamines/speed _____	☐ Cocaine _____	☐ Inhalants (e.g., glue, gas) _____	☐ Ecstacy _____
☐Barbiturates/downers _____	☐ Crack cocaine _____	☐ Marijuana or hashish _____	☐ Other(s) _____

11. If "other(s)", please specify

_____

_____

Presence of family during your childhood:

	Present entire childhood	Present part of childhood	Not present at all	Don't have	Mental health issues?
Mother					
Father					
Stepmother					
Stepfather					
Brother(s)					
Sister(s)					

12. Please describe your childhood family experience:

- ☐ Outstanding home environment
- ☐ Chaotic home environment
- ☐ Witnessed physical/verbal/sexual abuse toward others
- ☐ Experienced physical/verbal/sexual abuse from Others
- ☐ What I consider to be a normal family
- ☐ Other (please specify)

13. If "other", please specify

_____

_____

Is there a history of addictive behaviors in your family? Please use the box below to indicate the type of addiction, and if the abuse is active or in remission:

- ☐ No one
- ☐ Father
- ☐ Mother
- ☐ Sibling(s)
- ☐ Grandparent(s)
- ☐ Stepparent (live-in)
- ☐ Uncle(s)/Aunts
- ☐ Spouse/Significant
- ☐ Children
- ☐ Other(s)

14. If "other please specify

_____

_____

Describe your current physical health:

☐Excellent ☐ Good

☐Fair ☐ Poor

15. If you are currently under care of a physician, please specify:

	Physician	Condition	Treatment
1			
2			

16.Which medications (prescription and non-prescription) are you currently taking?

	Medication	Dosage	Since when?	Adverse effects
1				
2				
3				
4				

17.Marital status Please check and specify when applicable:

☐Single, never married ☐ Engaged (if so, for how long?)_____

☐ Married (If so, for how long?)_____

☐Separated (if so, for how long?)_____

☐ Divorced (If so, for how long?)_____

☐Divorce in process (If so, for how long?) _____

☐Prior marriages (self)

☐Prior marriages (partner) relationship

☐Never been in a long term

18.Relationship satisfaction:

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Somewhat satisfied
- ☐ Dissatisfied
- ☐ Very dissatisfied

19.Describe any past or current significant issues in your intimate relationships:

_____

_____

_____

_____

20.Describe any past or current significant issues in your immediate family relationships

_____

_____

21.About your family- feel free to add extra pertinent information in the box below:

	Age(s), if alive	Name(s)	Your age at the time of their
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

22.Additional info

List all persons currently living in your household:

	Name	Gender	Relationship to you	Current age
1				
2				
3				

23.If currently employed:

What is your occupation?

Do you enjoy your work?

How many hours a day do you work?

Do you take work home with you?

Do you travel for work?

If so, how often are you typically away, and for how long?

24.Please check levels of education that you have completed and name the subject of the degree.

☐High School ☐Vocational Training ☐Associates
☐Bachelors Degree ☐Masters Degree ☐PhD

25.

How is your social interaction? Check all that apply:

☐Normal social interaction ☐Isolate myself ☐Very shy
☐Co-dependent ☐Inappropriate sexual behavior ☐Dominate others
☐ Friends that are not healthy for me ☐ Co-dependent ☐Other*

*If "other", please specify

_____

_____

26.What is your current financial situation? Check all that apply:

- ☐ Poverty or below-poverty
- ☐ Large indebtedness
- ☐ No current financial problems
- ☐ Relationship conflicts over income
- ☐ Impulsive spending
- ☐ Low to moderate financial problems
- ☐ Other (please specify)

*If "other", please specify

_____

_____

27. What is your stress level?

- ☐ Low
- ☐ Average
- ☐ Considerable
- ☐ Unbearable

28.What are the major causes of your stress? (marital/financial/career/sexual/family/ health/unfulfilled expectations, etc)

29.What are your methods and strategies for coping with stress?

30.What are your passions and leisure pursuits?

31.Do you exercise? If yes, what type of exercise, how often and for how long, on average?

32.Current symptoms checklist. Rate intensity of symptoms currently present:

Abusive behavior towards others	None	Mild	Moderate	Severe
Aggressive Behaviors				
Agitation				
Appetite Disturbance				

Bingeing / Purging				
Chronic pain				
Depressed Mood				
Difficulty concentrating				
Elevated Mood				
Emotional Trauma Victim				
Fatigue / Low energy				
Generalized Anxiety				
Grief				
Guilt				
Highly emotional				
Hopelessness				
Hyperactivity				
Irritability				
Mood swings				
Obsessions / Compulsions				
Panic attacks				
Phobia				
Physical trauma victim				
Poor grooming/hygiene				
Self-mutilation				
Sexual dysfunction				
Sexual trauma victim				
Significant weight gain/loss				
Sleep disturbance				
Physical complaints				
Sadness				
Substance abuse				
Worthlessness				

*If "other", please specify

_____

_____

33. What would you like to be different in your life as a result of therapy?

_____

_____

34. Is there anything else you think I should know, or that you would like to share, that would help me understand you and your situation more completely?

_____

_____

- **I have thoroughly read and fully understand the Informed Consent and the therapy policy pages of this document.**
- **I understand that I am financially responsible for charges and fees incurred. And I agree to honor the 24-hour cancellation policy.**
- **I understand limits of confidentiality and all mandated reporting by my therapist.**
- **I understand that any disclosures of sex with a minor, viewing underage pornography, or sexual behavior with minors (a person under the age of 18) is reportable under law by all Life Connections Counseling, LLC therapists.**
- **I agree to respect the boundaries of contact between sessions and understand email and text is not an appropriate form of processing what is best discussed in session.**
- **I understand that emailing, texting and cell phone are not guaranteed as confidential.**
- **I understand and agree to the illness policy and will conduct sessions via phone if I am ill and agree that if my therapist is ill, she/he will conduct via phone.**
- **I understand and agree to the social media boundaries and policy.**
- **I have answered all questions in full, truthfully and to the best of my knowledge.**
- **I have had all questions about this document answered and sign willingly.**
- **I authorize my therapist employed with Life Connections Counseling, LLC. to provide psychotherapeutic treatment for me, the client, signing below:**

Client's name (printed): _____

Client's signature:_____ Date:_____

Therapist's name (printed):_____

Therapist's signature:_____ Date:_____

Client Credit Card Authorization Form

Please note that the information on this form will be securely entered and stored in a HIPAA compliant online virtual terminal that is password protected for your safety. Once your information has been entered by your therapist to the secured terminal, these paper forms will be shredded and destroyed immediately to protect your information. While all secure methods to protect your information are in place, and we take your safety seriously, no company can 100% guarantee that any online system cannot be breached, thus you are accepting responsibility and risk in allowing Life Connections Counseling, LLC to store your information for therapy charges.

I authorize my therapist with Life Connections Counseling, LLC. to keep my signature and card information on a virtual terminal file that is password protected and HIPAA compliant in order to charge therapy session fees (individual, group, workshops, couples, family or other), and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials, and/or fees), or for any appointments with my therapist that are not cancelled 24 hours before the scheduled appointment time to be charged to my credit, charge, or debit card as filled out below for therapy services provided to:

Therapy Client's Name:_____ (Please Print)

I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in an online protected client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for ongoing services or materials will normally be posted to my credit/debit/flex card account within 48 hours of each session date.

Additionally, I agree that the card listed below may be charged by my therapist with Life Connections Counseling, LLC. In order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials (i.e. books, CD's, DVD's) that I have not returned within one week of completion of my therapy services. I understand that if a charge back fee is incurred or a retrieval fee of is incurred, I am responsible for these fees._____ (Initial here)

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact my therapist with Life Connections Counseling, LLC for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my therapist and those attempts have failed. _____ (Initial here)

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by this person's therapist at Life Connections Counseling, LLC.
_____ (Initial here)

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name (print):_____

Signature_____

Relationship to client:_____

Billing Address:_____

Zip Code:_____

Card Type (circle one): 1. Visa 2.Mastercard 3.AMEX

Card Number: _____-_____-_____-_____

Exp. Date:

CVV:

I understand that my therapy sessions will be charged via this form and not by swiping my card on the day of my session unless cancelled 24 hours in advance:

Signature:_____ **Date:**_____