# New Hope Counseling Center

Name _____ Date of Birth _____
Today's date _____
Address_____
Street City & State Zip
Phone: Home _____ Work_____
Cell _____
E-mail address:
_____

May I call/leave a message at home? _____ At work? _____ Cell phone? _____
E-mail?_____
Occupation _____
Employer name & address
_____
_____
Education (last grade completed) _____
Current relationship status _____
Local emergency contact person _____
Relationship to you _____
Home phone _____ Work phone _____
Please describe the issues or concerns which you would like to address in therapy at this time:
_____
_____
_____
_____
Have you been in therapy or hypnotherapy? _____
If yes, please state when and where
_____
Please describe any illness, loss, accident, or hospitalization that had a big impact on your life and give the dates of their occurrences
_____
_____
_____
Do you have any major health concerns?

Please list any medication(s) you are currently taking and the dosage

_____

_____

Primary physician _____
Phone_____
Physician's address

_____

Have you ever had a psychiatric hospitalization? If so, when

Name of person who referred you _____
May I acknowledge the referral? _____
Is there any other information which you feel may be useful to your treatment?

I have read the Informed Consent on the next page and agree to the conditions of therapy. I also understand that if I do not cancel my appointment within 24 hours of the allotted time my credit card will be charged the full fee for the session.

Please provide credit card information. The card will only be charged if I do not cancel in the appropriate amount of time. All information will be kept secure and confidential.

Name of Credit Card Holder Signature

Type of Card (Visa, MasterCard, American Express)

Account Number

Expiration Date Security Code (on back of card)

# NEW HOPE COUNSELING CENTER
## Informed Consent

Confidentiality: Communications between client and counselor are confidential and will not be revealed unless required by law such as situations of child abuse or threats of physical harm to self or others. Your counselor will be discreet if it is necessary to contact you at home or at work.

Counseling Fees: Payment for services is expected at the time of service. The 50 minute counseling session is per session. We do offer reduced sliding scale fees depending upon your current circumstances. Please discuss this with your counselor on the initial visit.

Cancellation of Appointments: If you must cancel your appointment, please call the counselor 24 hours in advance. If less than 24 hour notice is given you will be charged the full fee.

Emergency Procedures: If you have an emergency, please call 911 or go to the nearest hospital emergency room.

By signing this form, I have read the above information and voluntarily request counseling services. I agree to these terms and conditions and I understand that I have the right to withdraw at any time and that there are likely benefits and risks of therapy. The issues of confidentiality, privacy and their limits are understood.

Clients Name: _____

Clients Signature: _____

Date: _____