DENISE WARNER, LMHC, NCC
Counseling Services

Client Information

Today's Date _____

Name:_____ Age: _____ Date of Birth: ____/____/____
Last First

Home address: _____
Street City Zip

Home Phone: _____ Cell _____ Other: _____

Which is the preferred method to contact you? _____

Employer/School: _____

Marital Status: _____ if divorced/widowed, for how long? _____

Spouse's Name _____ Age _____

Other Significant Family Members:

_____	_____	_____
First name	age	relationship to the client
_____	_____	_____
First name	age	relationship to the client
_____	_____	_____
First name	age	relationship to the client
_____	_____	_____
First name	age	relationship to the client

Please provide a brief description of why you are seeking counseling at this time:

_____
_____
_____
_____

How long has this been a problem for you?

_____

Please circle any of the following symptoms or circumstances that currently apply to you

Stress	Excessive spending	Repetitive behaviors
Panic	Impulsive Behavior	Self-mutilation
Compulsive Behavior	Sexual Problems	Feeling worthless or excessively guilty
Low Self-Esteem/Confidence	Legal Matters	Impaired concentration or distractibility
Shyness	Anxiety	Difficulty with friends
Emotional Abuse	Excessive fear or worry	Mood Swings
Physical Abuse	Feeling of unreality	Spiritual struggles
Sexual Abuse	Lightheaded	Drug/Alcohol Use
Parenting Challenges	Shortness of breath	Making career choices
Irritability	Depressed mood	Financial stress
Thoughts of self-harm	Loss of interest or pleasure	Physical illness
Problems with spouse/partner	Change in appetite or weight	Racing thoughts
Anger	Sleep disturbance	Other
Bad Dreams	Decreased interest in physical activity	_____
Unwanted Thoughts	Fatigue or loss of energy	_____

Do you have a history of substance abuse? Y / N
If yes, give a brief description:
_____
_____
_____

Past psychiatric/therapy treatment including hospitalizations: Y / N
If yes, please give a brief description:

Have you ever been suicidal? Y / N
If yes, when and briefly describe:
_____
_____
_____

Please feel free to discuss any questions with me during your session

Are you currently suicidal? Y / N
If Yes, Describe feelings/situation:

_____
_____
_____

Medication(s): _____

_____

Are you taking these medications as prescribed? Y / N

Psychiatrist:

_____
Name contact information (address, phone number)

General Practitioner:

_____
Name contact information (address, phone number)

Person responsible for payment of services:
_____

Relationship to client:
_____

Contact information (if different from above):

Address:
_____
Street City Zip Code

Phone(s):
_____

Please feel free to discuss any questions with me during your session

DENISE WARNER, LMHC, NCC
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Informed Consent and Agreement for Therapeutic Services

Please read this agreement carefully and feel free to ask questions. Your signature on this form indicates your understanding and acceptance of the terms outlined.

Seeking help is an important and serious matter. Psychotherapy is a process of change that focuses on behaviors, emotions and the way we think. I am trained to listen, effectively conceptualize problems and then provide realistic and workable skills and interventions to you, the client. These tasks are all geared toward assisting you in bringing about the desired changes in your life. I believe that the process of therapy is a collaborative process and it is our job together to work toward identified goals. Therapy is only as effective as the amount of effort you put into it. The relationship between the therapist and the client is key to helping resolve difficulties and it is important that all parties have a sense of understanding and trust in the process. Please feel free to ask questions and share concerns at any time throughout our time together.

Length and Frequency of Treatment: This is a highly variable decision that revolves around the nature of the problem, agreed upon goals of treatment, the ability and motivation of the individual and/or family to actively pursue agreed upon goals, and the amount of support required to integrate and maintain the improvements. I generally see people weekly during the initial assessment and treatment stages and then we progress to a once or twice a month regimen as needed. There may be times where multiple sessions per week are required to deal with a crisis or a particularly difficult issue. When doing family work, clients may be seen individually and in various combinations at various points in the treatment process.

Appointments are usually for 50 minutes of client contact time each hour with the other 10 minutes used for fee collection and documentation. Appointment times are reserved exclusively for you and your family members. Thus *"no shows" and cancellations made under 24 hours will be charged the full* fee and are not reimbursable through insurance. There will be no charge for cancellations made 24 hours in advance. If you are running late, call and come anyway and use the remaining time already reserved and charged to you. It is also important for therapy to be effective to establish a consistent schedule. Frequent changes in appointments distract from the necessary therapeutic rhythm essential for meaningful and lasting results.

Telephone Communications and Emergencies: During regular operating hours (9:00 am to 5:00 pm) there is an answering service available. Feel free to leave a message with them during those hours. I will attempt to return your phone call between appointments or later in the day or evening. Please be sure you leave return phone numbers each time you call, because I

may not be returning your call from the office and may not have a copy of your phone number with me. I am not able to respond or intervene in clinical emergencies (suicide attempts, runaways, behavioral aggression, abuse episodes) and you should dial 911 or go to your nearest hospital emergency room. Please then leave word on my office (as soon as you are able) that you have experienced a crisis, the nature of the problem and a number to call you back sometime during the day.

Extended phone calls (more than 10 minutes) will be billed at my hourly rate. Brief phone calls and appointment scheduling are not billed.

Confidentiality: Problems and intimate details shared and discussed in therapy will be treated confidentially and will not be shared with other family members, insurance companies or professionals without your written consent. However information shared that has to do with knowledge or suspicion of abuse, certain aspects of HIV, and/or situations that constitute a clear and immediate danger to self and others is not considered privileged and as a licensed professional in the state of Florida I am required to disclose my concerns to appropriate designated authorities. By virtue of the State of Florida, I am a mandated reporter of those types of concerns.

Confidentiality can also be waived by order of a judge in a disputed child custody case. Couples or adult family members seen in family therapy must all sign a release of information for treatment details to be shared even if the requested information is to be shared with your attorney. Clinical records in the state of Florida are the property of the practicing professional, not the client and will not be released to you. However, I will be happy to provide a narrative summary of your treatment to you, your attorney or other professional upon your written request.

Credentials: I am a Florida Licensed Mental Health Counselor and I am recognized by the National Board of Certified Counselors. I received a Bachelor's degree in Psychology from the University of North Florida in 1993 and a Masters in Mental Health Counseling in 1997. I have approximately 20 years post-masters experience as a professional therapist. I have practical experience providing clinical intervention to clients from varying environments with different treatment needs. I will provide counseling to clients only in the areas of my expertise. I will not offer guidance, advice or counseling in any specialized area in which I am not qualified, certified or licensed. If it becomes apparent that the client has challenges or problems that are beyond my expertise, I will request that the client seek advice, council or services from a qualified professional to help them in that area. I will reserve the right to terminate the relationship until the client has done so if the challenges or problem impedes the forward movement of the counseling process.

Litigation:
Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce, custody disputes, injuries,

lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call on Denise Warner to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Fees:
Payment is due at the time of service. Rates are $180.00 per hour. Fees can be made through cash or check. Billing service is available for $25.00 per month. Chargeable time includes therapy sessions, writing of reports and correspondence and contacts with other professionals on your behalf. A $25.00 monthly service fee will be charged to all unpaid balances that exceed 30 days. Unpaid balances that exceed 90 days may be referred to collections, small claims court and/or to your credit bureau

Insurance:
Your insurance company may pay for outpatient mental health services from a licensed mental health counselor. It is up to you to check with your insurance representative to determine what is reimbursable, at what percentage and if there is a deductible that needs to be met. Insurance only pays for the actual therapy session. If you plan to file a claim with your insurance carrier I will not do that for you, however I will be happy to provide any documentation that you may need so that you may be reimbursed by your insurance carrier. Please note that you remain financially responsible for the full amount of each session.

By signing below, I

- Understand that Denise Warner is a mandated reporter
- Acknowledge the explanation of limitations to confidentiality
- Authorize treatment
- Accept responsibility to pay all fees due
- Waive any right I may otherwise have to seek to use the record of my counseling or to compel the testimony of Denise J Warner as evidence in any judicial proceeding

_____ _____

I have read and received a copy of this consent Date

Financial Agreement

Therapy is financial investment and therefore requires serious consideration. Please read this agreement carefully.

Payment is due in full at the time the service is provided.

The hourly fee is $180.00. Fees can be made through cash or check, or credit card.

Chargeable time includes therapy sessions, writing of reports and correspondence and contacts with other professionals on your behalf. Extended phone calls (more than 10 minutes) will be billed at my hourly rate. Brief phone calls and appointment scheduling are not billed.

A $25.00 monthly service fee will be charged to all unpaid balances that exceed 30 days. Unpaid balances that exceed 90 days may be referred to collections, small claims court and/or to your credit bureau.

Insurance:

Your insurance company may pay for outpatient mental health services from a licensed mental health counselor. It is up to you to check with your insurance representative to determine what is reimbursable, at what percentage and if there is a deductible that needs to be met. Insurance only pays for the actual therapy session. If you plan to file a claim with your insurance carrier I will not do that for you, however I will be happy to provide any documentation that you may need so that you may be reimbursed by your insurance carrier. Please note that you remain financially responsible for the full amount of each session.

_____ _____

Client's Signature Date

CANCELLATION POLICY

The scheduling of an appointment is a verbal agreement between therapist and client to be present at the determined time. Once an appointment is scheduled, that time is reserved exclusively for you.

Because the rescheduling and cancellation of therapy sessions is disruptive to the therapeutic process, please consider it for only for unforeseen circumstances and true emergencies.

We understand that sometimes emergencies arise and you may need to cancel or reschedule an appointment If you become aware of a circumstance which makes it impossible for you to keep the agreed upon appointment, please notify the office as soon as possible. We request that you notify us at least 24 hours before your scheduled appointment time.

If an appointment is not cancelled prior to 24 hours you will be billed for the full session fee. These fees are not reimbursable through insurance. (Unavoidable circumstances may warrant special consideration)

To cancel or reschedule an appointment, call (904) 703-0121. Please do not e-mail your request to cancel, as it may not be received in a timely manner.

Thank you for your consideration regarding this important matter.

I understand the cancellation policy and agree to give 24-hour notice for any cancellations or be charged the full session fee.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Today's Date