Client Demographic Form

DATE: ________________ CLINICIAN NAME: Leah Crowling, LMFT

(Please provide a photo ID for verification purposes)

Adult clients, please complete the following (Please note, all applicable information is required):

Client Name: ____

Address: ____

Street City State Zip

Phone: ____________________ Is it okay to leave messages?_______

Emergency Contact: ________________ Phone:________________

Gender:______________ Date of Birth:______________

Marital Status: Single_________ Married_________ Divorced__________

Domestic Partner________ Dating_______ Separated______ Widowed ______

Occupation:____

If client is under 18, please complete the following:

Client Name: ____

Address: ____

Street City State Zip

Gender:______________ Date of Birth:______________

School:_____________________________ Grade: ______________

Biological Parent's/Legal Guardian's Marital Status:________________

Is there a formal custody arrangement with regard to this minor?_______

Are both parents aware that the minor is receiving treatment?__________

Do both parents consent to the minor receiving treatment?______________

First Parent's Name: _____________________________________

Address: ____

Street City State Zip

Phone:____

Home Cell/Work

Second Parent's Name:_____________________________________

Address: ____

Street City, State, Zip

Phone:____

Home Cell/Work

Parent email(s):____

Professional Service Agreement

I welcome the opportunity to be of service to you and your family.

As a client you agree to the following:

FEES AND PAYMENT FOR SERVICES: Session length is determined based on mutually agreed upon goals. The initial session will be billed as a **Diagnostic Clinical Evaluation, and subsequent sessions will be billed according to the length and nature of the session.** All fees for services are outlined in Chapel Hill Family Counseling's (CHFC) Fee Schedule form and are subject to change annually. Sessions lasting 38-52 minutes will be billed as 45-minute sessions, and those lasting 53-60 minutes will be billed as 60-minute sessions. Please note that telephone consultations over 15 minutes, written communication requests and court-related clinical services may be invoiced at 15-minute intervals and are not covered by insurance. Services will be discontinued if fees are not paid in a timely manner. Delinquency of 30 days may result in termination of treatment. Additionally, accounts that have no payments for over 90 days may be sent to an outside collection agency. You agree that in the event the clinician is forced to file legal proceedings for payment of fees, in addition to the fee owed, you are responsible for all legal fees and court costs incurred by the clinician in the collection proceedings. ________*Client's Initials*

CANCELLATION POLICY: CHFC requires at least 24 hours advance notice of a session cancellation. If less than 24-hour notice is given, your clinician may charge you the full agreed upon rate of services. Please note that standing appointment times and the provision of services may be terminated at the clinician's discretion due to appointment cancellations exceeding 25% of scheduled appointments. Missed visits and cancellations less that 24 hours in advance are billed at the full session rate and billed directly to the client.
__________*Client's Initials*

EMERGENCIES: CHFC does not have the staffing or resources to provide 24-hour clinical emergency support services. This practice is therefore not an appropriate fit for clients in need of crisis management or on-call support services between sessions. If you are experiencing a life-threatening clinical

emergency, please contact 911 or go to your nearest hospital emergency room.
__________*Client's Initials*

CONFIDENTIALITY: The information you share in session with your clinician is confidential and will not be disclosed without your written permission except when you may pose a danger to yourself or others or as required under North Carolina and Federal law. IF you disclose information related to a suspected child or elder abuse, the clinician is obligated to report it. If your clinician receives a court order to release your information, the clinician is obligated to honor it. Information regarding children under the age of 12 years may be shared with legal guardians but is otherwise subject to the same protections of confidentiality. When working with children, it is essential that they be able to trust their therapist. In that regard, we keep the confidentiality of a child in the same way we keep the confidentiality of an adult. As the parent or guardian, however, you have the right and responsibility to question and understand the nature of our activities and progress with your child. We must use our clinical discretion as to what is an appropriate disclosure. In general, we will not release specific information that the child provides us, with the exception of the conditions listed below. We will discuss with you your child's progress, require your participation in treatment, and share any information your child has requested we discuss. __________*Client's Initials*

CONFIDENTIALITY EXCEPTIONS:

a) If a therapist suspects that a child or elder abuse or neglect has occurred, the law requires that it be reported to the authorities.
b) If sexual exploitation by another therapist is reported, your therapist is required to notify the appropriate person(s) or agencies.
c) If a therapist believes that your child is a clear and imminent danger to self or others, the therapist must intervene.
d) If it becomes necessary to contact an attorney or a collection agency, then your name, identifying information about how to reach you, an amount owed become available to these agents.
e) In legal proceedings, patient-therapist communications are typically privileged. The exception, however, occurs when we are ordered by the court to disclose information that the court feels is essential to the proper administration of justice. __________*Client's Initials*

ELECTRONICALLY MEDITATED PSYCHOTHERAPY: CHFC cannot guarantee the privacy of email or phone therapy. Therefore, clients acknowledge the potential risk to confidentiality by using these technologies. Emails and voicemails will typically be returned within 1-2 business days and should therefore never be used in the case of an emergency. Additionally, at this time insurance companies do not provide coverage/reimbursement for electronically

mediated or phone-based services. Clients are expected to pay the therapist's regular fee for time spent interacting with the client by email or phone.
_________*Client's Initials*

CONSENT TO TREATMENT: By signing this letter, I consent to treatment. I understand that I always retain the right to terminate treatment or obtain a second opinion.

I certify that I have read this Professional Service Agreement and understand and agree to abide by all its terms.

____ Date:_____________
Client Signature (for clients 12 years and above)

____ Date:_____________
Parent/Legal Guardian Signature (for clients under 18 years old)

____ Date:_____________
Therapist's Signature