The Practice of Alexis Honeycutt, MA, LMHC

Counseling Agreement

The following is an agreement between Alexis Honeycutt, 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 understand that after 3 cancellations I will not be able to be put back on therapist schedule.
5. **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. = $150.00/ 90 min. = $225.00)**
6. Phone calls with Alexis Honeycutt, LMHC are billed in 15-minute increments 15 min. = $37.50; with a billed minimum of 15 minutes.

Financial Agreements:

1. I have agreed on the following session rate of **$ 150** 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. Receipts will be provided **only** if expressly requested before the beginning of session.
5. Payment options include: HSA/FSA, Credit/Debit 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 Alexis Honeycutt, LLC to charge this credit card for sessions, phone call fees, cancellation fees (see above) as appropriate. This credit/debit card will also be used for all fees that have not been paid within 30 days. I understand that I may revoke this agreement at any time by providing a request in writing.

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 Alexis Honeycutt, 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

While I am trained in Gottman Method Couples Therapy, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for the provision of those services. The Gottman Institute nor its agents have any responsibility for the services you receive.

Electronic Communication Consent Form

I acknowledge that commonly used e-mail and texting services are not secure.

I have been given the opportunity to discuss electronic communication with Alexis Honeycutt LMHC, and have had all my questions answered.

In consideration of my desire to use electronic communication as supplement to in-person office visits with my provider, I hereby consent to electronic communication via non-secure e-mail and text services.

I understand that I may revoke my consent to communicate electronically at any time by notifying Alexis Honeycutt, LMHC in writing, but if I do, the revocation will not have any effecton actions my healthcare provider has already taken in reliance on my consent.

I agree to release my provider and the practice from any and all liability that may occur due to electronic communication over a non-secure network.

I further agree to be held accountable for the patient responsibilities as outlined.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with Alexis Honeycutt, LMHC

Signature_____ Date _____

Permission For Digitally Recording or Video Taping Therapy Sessions

As a primary tool in Gottman Method Couples Therapy, and in order to augment your therapy work, I use digital recording feedback as part of therapy sessions. This means that I may digitally record you during specific dialogues or exercises or during entire sessions.

In addition to in-session use, I may wish to use the video recordings to receive consultation from the Gottman Institute. During this process, your name will be kept confidential. In addition, all matters discussed in consultation will remain completely confidential within the Gottman Institute staff or independently practicing Gottman consultant. Your confidentiality under HIPPA extends to any ancillary practitioner who reviews the recording for the purpose of providing feedback. The digital recordings are NOT part of your clinical record and will be used for no other purpose. All **digital recordings will be erased** when they are no longer needed for the above stated purpose.

These digital recordings are my property and will remain in my possession during the course of your therapy until such time as they are erased. All digital recordings are stored according to HIPPA compliant rules and are safe and confidential.

Signature: _____ 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	