RB Counseling, LLC

INFORMED CONSENT DOCUMENT

I acknowledge I am voluntarily seeking therapy from Rhonda Bethmann, LPC. I understand I am seeking services for specific reasons at this time and during the course of my therapy, other issues may arise which will be dealt with in my sessions.

I understand my therapist will strive to provide a safe, secure environment in which I may express myself freely, without concern of judgment. My therapist will help me to clarify my thoughts and perceptions through questioning and guidance. She will assist me in exploring my feelings, thoughts and relationships. I understand she will help guide me through the issues I present to her and help me deal with them in a healthy way which promotes my emotional growth and well-being. I understand I am responsible for assisting my therapist in my growth and I am therefore responsible for completing any homework assignments given.

I understand there are risks and benefits to counseling. During my therapy I may remember unpleasant events and these may result in strong emotions. My therapy may also impact my relationships with my family and/or significant others. I am aware sometimes things may get worse before they get better. Some benefits from therapy may be an improved ability to relate to and communicate with others, a deeper understanding of self, and an increased ability to deal with everyday stress and pressure.

I further understand all information disclosed in session is confidential. The only exceptions to disclosure are in the following situations where disclosure is required by law:

1. If I present an imminent danger to myself or others
2. When there is an indication of abuse of a child or dependent adult
3. If my therapist is ordered by the court to turn over my records

I agree to pay $160 per 50 minute individual session, and $210 per 50 minute couples session. That rate will increase by $10 on the first day of January each year. Reports, consultations or other services will be billed at the same rate.

I agree to give my therapist at least 24 hours notice if I must cancel a scheduled appointment. If I do not notify my therapist BY TEXT within 24 hours, I understand I will be charged the regular fee for my missed session and the fee will be charged to the credit or debit card I provide, and allow, my therapist to keep on file.

I understand my therapist does not become involved in, or testify in, court proceedings including, but not limited to, proceedings related to divorce or child custody.

I have had the opportunity to read this informed consent document and discuss any questions or concerns I have regarding my treatment with my therapist prior to treatment.

Client Signature____ Date_________________________

I have reviewed the HIPPA regulations related to the counseling services provided to me by RB Counseling, LLC.

Client Signature____Date_________________________

Name: ____ Birthdate: ___________________

Address: ____ Marital Status: _____________

City, State, Zip: ____

Cell phone: _____________________ Home phone: ___________________ May I leave a message? _______

Email____

Emergency Contact: ___________________________ Phone#/Relationship: ____________________________

Employer: _________________________________ Position/title: ___________________________________

What is the main reason you are seeking counseling services? ____

____

What do you hope to achieve in therapy? ____

____

How did you find RB Counseling? ___Internet ___Facebook ____Referred by: _________________________

Why did you choose RB Counseling? ____

Have you ever been in therapy? __________ Length of time in therapy: __________________________________

If yes, name(s) of provider(s): ____

Reason for termination: ____

Psychiatrist____phone#_______________________

Primary Care Physician: ____ phone#_______________________

Current Medications: ____

____

Current Medical Conditions: ____

List any family history of emotional or mental illness including alcohol or substance abuse: ________________

____

____

If you are in a relationship, what is the quality of the relationship?

____Excellent ___Good ___Fair ___Some Problems ___Major Problems

Comments____

____

Please check all that apply:

__Nausea
__Worry
__Fatigue
__Phobias
__Anxiety
__Crying easily
__Feeling superior to others
__Depression
__Panic Attacks
__Nightmares
__Irritability
__Headaches
__Overeating
__Suicidal thoughts
__Problem drinker
__Low energy
__Loss of appetite
__Angry Outbursts
__Trouble concentrating
__Trouble remembering things
__Trouble making decisions
__Trouble falling asleep
__Trouble staying asleep
__Feeling inferior to others
__Loss of sexual interest
__Tightness in stomach

Client Signature____Date_____________________