

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 \$150 per 50 minute individual session, and \$200 per 50 minute couples session. That rate will increase by \$10 on the first day of January each year, beginning in 2024. Reports, consultations or other services will be billed at the same rate. My therapist may offer a reduced fee to a small number of clients and a \$5 discount for cash payments.

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 _____

RB Counseling, LLC

CLIENT CREDIT CARD AUTHORIZATION FORM

I, _____, hereby authorize RB Counseling, LLC to bill my credit card at the usual session fee for professional services including the following:

- Missed appointments (No call / No show)
- Appointments I cancel with less than a 24 hour notice
- Telephone consultations (exceeding 20 minutes) to other professionals \$25 fee
- Completion of paperwork requested by me, or required for my employer, disability, or other professional (billed at my regular hourly rate)
- Returned checks and associated bank fees

Credit Card Type: ___ Visa ___ Master Card ___ Discover ___ Amex

Credit Card Number: _____ Exp ___ / ___ CCV _____

Name on Credit Card: _____

Billing Address: _____

City/State/Zip: _____

Email Address: _____

By signing below, I am stating I understand the billing policy and I am authorizing RB Counseling, LLC to bill my credit card for professional services as described above.

Print Cardholder's Name _____

Cardholder's Signature _____ Date: ___ / ___ / ___

This form will be stored securely and may be updated upon request at any time.

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:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Depression | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Trouble making decisions |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Problem drinker | <input type="checkbox"/> Trouble falling asleep |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Low energy | <input type="checkbox"/> Trouble staying asleep |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Feeling inferior to others |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Headaches | <input type="checkbox"/> Angry Outbursts | <input type="checkbox"/> Loss of sexual interest |
| <input type="checkbox"/> Crying easily | <input type="checkbox"/> Overeating | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Tightness in stomach |
| <input type="checkbox"/> Feeling superior to others | <input type="checkbox"/> Trouble remembering things | | |

Client Signature _____ Date _____