"Encouraging Growth and Enhancing Relationships"

Welcome to Alliance Counseling & Therapy. To help us meet your needs, please complete this form in ink. If you have any questions or need assistance, please ask us.

Date: ____________________

Client 1:

Name:__________________________________ Date of Birth: _____________ Age: ___ Sex: M F

Address: ________________________________ City: ____________________ State: __ Zip: _________

Phone: ☐ Home: (___) _____________ ☐ Cell: (___) _____________ ☐ Work: (___) _____________
(Please check the best number to use in contacting you)

May we leave a message? Home: Y N Cell: Y N Work: Y N

Email address for messages: ____

How important is spirituality to you? 0 1 2 3 4 5 6 7 8 9 10 (Circle your response)
Least ... Most

Do you attend church? Y N Church name: ____

Employer: ____

Physician: ____

Current medical conditions: ____

Current medications: ____

Client 2:

Name: __________________________________ Date of Birth: _____________ Age: ___ Sex: M F

Address: ________________________________ City: ____________________ State: __ Zip: _________

Phone: ☐ Home: (___) _____________ ☐ Cell: (___) _____________ ☐ Work: (___) _____________
(Please check the best number to use in contacting you)

May we leave a message? Home: Y N Cell: Y N Work: Y N

Email address for messages: ____

How important is spirituality to you? 0 1 2 3 4 5 6 7 8 9 10 (Circle your response)
Least ... Most

Do you attend church? Y N Church name: ____

Employer: ____

Physician: ____

Current medical conditions: ____

Current medications: ____

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Marital Status: Married_____ Living Together______ Separated_____ Divorced_____

Please list children's names and ages: ____

____

In case of emergency, contact:__________________________________ Relationship:________________

Contact's Home #: (___)____________ Cell #: (___)___________ Work #: (___)___________

Who referred you to ACT? ____________________________________ May we send them a note? Y N

What do you hope to accomplish from counseling? ____

____

____

List previous therapist(s) and counseling experience: ____

____

____

______________________________ ______________________________ ____________

Signed Name of Client 1 Printed Name of Client 1 Date

______________________________ ______________________________ ____________

Signed Name of Client 2 Printed Name of Client 2 Date

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Welcome to Alliance Counseling & Therapy (ACT). Thank you for trusting us to assist you with your personal concerns. Please take the time to read and understand this document. Be sure to ask your therapist about any portions which may be unclear to you.

Relationship counseling is a collaborative process between the couple and the ACT therapist(s). We want you to see yourselves as colleagues in the therapeutic journey. As we journey together, you bring to our work your need, your pain, and/or your desire and potential for healing and growth; we bring care, knowledge, skill, and experience. Client welfare is our primary concern and is the focus of all our therapeutic efforts. We believe that the therapeutic relationship should be continued only as long as the client is benefiting.

Services: Therapy is not easily described in general statements; it varies with the personalities of the clients and therapists, and with the particular issues you bring forward. There are many different methods that may be used, and our counselors will choose the approach they have found to be most effective in dealing with the type of issues that you hope to address. *Christian counseling is provided for clients expressly requesting it.*

Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings during the process such as sadness, anger, guilt, frustration, loneliness, and helplessness. However, the process of therapy often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress. Another possible benefit may be a greater understanding of personal goals and values; this may lead to greater maturity and happiness as an individual, couple, or family.

Meetings: Therapy will typically begin with an initial evaluation that can last from 1-3 sessions. During this time, we will jointly decide if ACT is the best solution to provide you with the counseling you need in order to meet your treatment goals. If counseling with ACT is continued, we will usually schedule one 50-minute session per week at an agreed time, although in some situations sessions may be longer or more frequent. If you decide ACT is not the best option to assist you with your therapeutic goals, we will be happy to provide you with a list of qualified alterative sources of treatment.

Financial Policy: ACT fees are $85 per 50 minute session ($120 per session for co-therapy). Fees will be prorated for sessions lasting longer than 50 minutes. We require payment at the time services are provided. You will be charged for sessions that are cancelled less than one day (24 hours) in advance of your scheduled appointment.

Insurance: The client grants ACT permission to file claims and furnish information to insurance carriers concerning treatment on behalf of the client. Employers or other third parties may have contracted for different levels of service (e.g., co-pay, deductibles, number of visits covered) for different groups of employees. Not all services are a covered benefit in all contracts, and some insurance companies arbitrarily select certain services they will not cover. *Therefore, it is the client's responsibility to verify coverage for these services with your insurance company. The client is responsible for all unreimbursed amounts.*

Court Proceedings: If an ACT therapist is involved in court proceedings related to a client, a fee of $300 will be required the day the subpoena is delivered. This fee will be applied to the two (2) hour minimum required for preparation work. All time spent in preparation, travel, waiting, and testifying will be charged at $150 per hour. A flat fee of $50 will be charged for each report of any type requested by the client from ACT for court purposes. In order to comply with laws of the State of Arkansas and with our professional Codes of Ethics for confidentiality, written authorization must be provided by the client(s) before any information may be released or testimony may be provided. For marital therapy, written authorization must be provided by **both** spouses for information related to all conjoint counseling sessions. For family therapy, written authorization must be provided by **all** family participants eighteen (18) or more years of age. For counseling of minors, written authorization must be provided by the parent(s) or legal guardian(s).

Permission to treat: I acknowledge that it is my choice to participate in counseling. I realize that the outcome of counseling depends upon my personal investment in the process. If I decide to terminate treatment, I will discuss this in advance with my counselor.

______________________	______________________	__________
Signed Name of Client	Printed Name of Client	Date
______________________	______________________	__________
Signed Name of Client	Printed Name of Client	Date