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 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 in my growth and responsible for practicing and implementing any tools I am 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 $170 per 50 minute individual session, and $220 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. I understand the fee must be paid before my next scheduled session.

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_____

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

Client Signature____Date_____________________