Joshua Sillitoe, MS, MFT Intern

CLIENT REGISTRATION/INFO FORM

Client Name: (Last):_____ **(First) :**_____**(Mid) Initial:** ___

Street Address: _____**Apt #** _____

City: _____**State:**_____ **Zip:** _____

Phone Number: _____**Cell #** _____

Martial Status: _____**Married** _____**Single** _____ **Divorced** _____ **Widowed**

Birth Date: _____ **Age:** _____ **Sex:** _____

Employer: _____ **Work #** _____**Retired** _____

Contact in Case of Emergency: _____**Relationship:**_____

Emergency Contact Number: _____

Spouse/Parent/Responsible Party

Spouse/Parent Name: _____ **Date of Birth:** _____

Employer: _____ **Work #**_____

Presenting Concerns:_____

_____

_____

_____

Medications:_____

Medical or Mental Health Diagnosis:_____

_____

I hereby consent to treatment by Joshua Sillitoe. I understand that I am ultimately responsible for all charges. Should a check be returned due to insufficient funds, a fee of $25.00 will be charged. Checks returned more than once will be assigned to a collection agency. In the event that my account is referred to a collection agency due to lack of payment on my part, I agree to pay all collection and legal fees that may be added to my account. I agree that there will be a 50% additional fee for all accounts turned over to collections.

Date:_____**Client/Responsible Party Signature:** _____

Joshua Sillitoe MS, MFT Intern

DISCLOSURE STATEMENT

Confidentiality

My professional code of AAMFT ethics prevents me from disclosing information that is shared in therapy or releasing information without your written consent. I cannot guarantee the confidentiality of other participants who are involved in your therapy process. The only exceptions to confidentiality are stated in the family therapy rights section of this disclosure statement.

_____ I understand that case notes are used for clinical purposes only, and are not subject to release for other legal or medical issues. In the event that documentation of therapy attendance, progress, prognosis, diagnosis, is needed, a letter stating these facts may be fashioned by Joshua Sillitoe at such time only upon my specific written consent. I will explain during my first session with Mr. Sillitoe, any pending legal, medical, or otherwise conflicting issues or matters such as mandated therapy, medical disability, custody cases, etc.

_____ If you are participating in couples or family counseling sessions, understand that all information shared in a joint session is open to all participants. Any information shared in an individual session is kept confidential with exception of behaviors that are damaging to the relationship. If this occurs the therapist will address this behavior in the couple's session.

_____ I understand in order for my therapist to provide optimal therapy, certain cases may be reviewed with other experienced and licensed therapists and trainers/trainees who are furthermore bound to the same provisions of client confidentiality and privacy. In these circumstances, all identifying information is withheld.

_____ I understand that electronic modes of communication with my therapist cannot, in most instances assure the highest level of confidentiality and may not be HIPPA, or otherwise compliant with state law governing confidentiality. I understand that my therapist will only initiate phone, e-mail, and text communication per my request which may consist of my initial phone, e-mail, or text communication with him. I understand there may be instances of confidentiality breeches when communicating with my therapist outside of his office. I will notify my therapist in writing if I do not wish to receive electronic communication in the future.

Fee Schedule and Financial Policy:

Sessions are 45 to 50 minutes long. The charge per session will be determined at the time of your initial appointment. Sessions that run over 50 minutes will be billed in 15 minute blocks of time according to the rate of $25 per 15 minutes.

_____ Fees can be paid by cash, check, or major credit card. Return check fee is $25.00. Letters or report fees are $50 per request and require 10 business days' notice with prepayment

of fee. All prepayments are non-refundable and are valid for one (1) calendar year of payment.

_____I do not accept insurance. Understand that I do not bill insurance because I value privacy; insurance companies require I provide a mental health diagnosis to bill.

Cancellations:

_____Your appointment time has been reserved for you because your time is valuable. You may call and leave a message on my voice mail to cancel prior to your session. **Sessions must be canceled within a minimum of 24 hours prior to your scheduled appointment. Should you choose to not call within 24 hours to cancel an appointment and do not show up for your scheduled time, you will incur a 50% charge of the full session fee.**

Your rights as a family therapy consumer are:

To receive information concerning the methods of therapy employed, the techniques used, the duration of therapy (If known), and the fee structure for services provided.
To seek a second opinion, if needed, I can provide you with names of other qualified professionals.
To terminate therapy at any time without any moral, legal, or financial obligations other than those already accrued.
To know our therapeutic relationship is confidential except under the following conditions:
a) If you threaten bodily harm or death to yourself or another person;
b) If you reveal information about physical abuse, sexual abuse or neglect in regard to a child or elder;
c) If you are in court ordered therapy;
d) If a court of law issues a legitimate subpoena.

Agreement:
1) I have read and understand the above policies.
2) I have read and understand the financial obligations.
3) I have been informed of my rights as a client.

Signed:_____ Date:_____
Client or parent/guardian

Signed:_____ Date:_____
Therapist

Joshua Sillitoe, MS, MFT Intern

1070 W Horizon Ridge Pkwy #204
Henderson, NV 89012
Phone (702) 637-4558

Fee Agreement

Name: _____

Name: _____

I agree to pay the amount of $85.00 per session at the time of the appointment.

Payments are to be made at the end of session. Should I be unable to make my scheduled appointment and fail to give my therapist a minimum of 24 hours' notice, I understand that I will be charged 50% of the full session fee.

I accept cash, check, or any major credit card (preferred)
If credit card is used, the client understands that the Square, Inc. credit card reader will be used, and accepts any possible risks associated with this form of payment processing.

Signed:_____ Date:_____
Client or parent/guardian

Signed:_____ Date:_____
Client or parent/guardian

Signed:_____ Date:_____
Therapist