George J. Limberakis, LPC
Associated Counseling Services, LLC
1399 S 700 East, Suite, 12B
Salt Lake City, UT 84105
801.487.4298

Client Name: ______________ Last ______________ First ______________ Middle

Address: ______________ Street ______________ City ______ State ______ Zip

Primary phone: ______________ 2nd phone: ______________
Okay to leave detailed message? Primary **Y or N** 2nd **Y or N**

Email address: ______________
For confirmation and adjusting of appointment times

Date of Birth/Age: ____________/________ Social Security # ______________

Currently: Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed ☐ Other ☐

Spouse/Partner ______________ Name ______________ Age ______________ Sex

Emergency Contacts

Primary contact ______________ Last ______________ First ______________ Phone

Address: ______________ Street ______________ City ______ State ______ Zip

Secondary contact ______________ Last ______________ First ______________ Phone

Address: ______________ Street ______________ City ______ State ______ Zip

Insurance Information

Primary insurance ______________ Company ______________ Phone

If you will seek reimbursement for services from an insurance company, **please provide a copy of your insurance card** or provide the requested information

______________ Street ______________ City ______ State ______ Zip

______________ Name of insured ______________ Date of Birth ______________ Relationship

______________ Group number ______________ Policy number

______________ Employer name and address

Secondary insurance ______________ Company ______________ Phone

______________ Street ______________ City ______ State ______ Zip

______________ Name of insured ______________ Date of Birth ______________ Relationship

______________ Group number ______________ Policy number

______________ Employer name and address

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Consent For Treatment

In seeking counseling services I, ________________________________, understand the following policies and procedures. I agree to read and, by initialing each section, indicate my understanding.

1. **Confidentiality:** All information I reveal to my counselor will be considered strictly confidential. Confidential information shared with supervisors or staff will be kept confidential. I understand that no information will be revealed to any outside party without my prior, written approval with the following exceptions:
   a. If I make threats of physical harm toward myself or others.
   b. If my counselor believes I am about to commit, or have been involved with, a violent crime.
   c. If my counselor believes that I am, or have been involved, in the physical abuse, sexual abuse, neglect or exploitation of a child or a disabled adult.
   d. If I have a life threatening medical emergency.
   e. If it is learned that I have a communicable disease that is reportable under Utah State Law and my counselor believes my behavior posses a risk of infection to others.
   f. If I fail to meet my obligation to pay for services, an outside agency or small claims court may be informed of my failure to meet my obligation.
   g. If a federal, state or local court orders (or subpoenas) my counselor or this facility to provide information to the court.
   h. I understand that my counselor will, when requested by my insurance company or other third party payer, release information regarding my diagnosis and/or treatment.
   i. I have received a copy of my counselor's Notice Of Privacy Practices - HIPAA

Initial here

2. **Treatment:** I agree to fully participate in my treatment in the following ways:
   a. I will assist my counselor in formulating and periodically reviewing my treatment goals.
   b. I will complete any homework that my counselor assigns to me to the best of my ability.
   c. I will discuss with my counselor any concerns that I have regarding my treatment.
   d. I will discuss, directly or in writing, with my counselor any dissatisfaction I have with my treatment.
   e. I will submit, in writing, any request to review the information contained in my clinical record.
   f. I understand that the goals of therapy are to improve intrapersonal as well as interpersonal functioning. The personal changes that I may experience as a result of therapy could alter present relationships in ways that cannot be predicted. I will discuss any changes in current relationships with significant others with my counselor.
   g. I understand that no promises can be made to me as to the results of treatment provided and that the nature of the therapeutic process is such that the personal issues for which I have sought treatment may, in some cases, worsen before improving or may not appear to improve at all with therapy.

Initial here

3. **Fees & Insurance:**
   a. I understand that my insurance company may pay a portion or none of the cost of my treatment. I may be required to meet my insurance plan deductible before any treatment is covered. I agree to pay all costs of treatment, including co-payments, that are not covered by my insurance plan and to keep my account current. If I fail to keep my account current, my counselor may discontinue treatment.
   b. I understand that I am responsible for the payment of all fees associated with my counseling at the time service is provided, unless other arrangements are agreed upon.
   c. I understand that my counselor will assist me in receiving reimbursement from my insurance company and I give permission for my counselor to provide information to my insurance company, for billing purposes.
   d. I understand that the fee charged to me per 25-minute session is $ 50.00, per 50 minute session is $ 100.00 and per 75 minute session is $ 150.00. Other ____
   e. I agree to discuss with my counselor any difficulties I may have in making timely payments to my account.
   f. I understand that, in order for my insurance company to be billed for my treatment, it is necessary for my counselor to formulate and submit to my insurance company a psychological diagnosis. If I have concerns about a psychiatric diagnosis becoming part of my medical record, I will discuss this with my counselor.

Initial here

4. Appointments:

a. I agree to arrive on time for my scheduled appointments.
b. I agree to give at least 24 hours notice if I am unable to keep a scheduled appointment.
c. I understand that my insurance company cannot be billed for missed appointments and that I am responsible for paying the full cost of missed and short-cancelled appointments.
d. I understand that I may be charged for missed or cancelled appointments if insufficient notice is given.
e. If it becomes necessary for my counselor to make changes to a scheduled appointment, I understand that all steps will be taken to inform me of the change as soon as possible.
f. I understand that my appointment will end 50 minutes from the time it is scheduled to begin. If I am late, no time will be added to the end of the appointment.

Initial here

These policies and procedures have been implemented to help assure that you receive maximum benefit from your counseling experience. Your counselor has agreed to abide by the Ethical Code of Standards endorsed by the American Counseling Association and the applicable laws of the State of Utah. If you are dissatisfied with the services provided to you, it is important that you make every effort to communicate your dissatisfaction to your counselor. If you desire to seek the services of another mental health provider, it is imperative that you inform your counselor of your intention to do so. If you need assistance locating another mental health care provider, I will be happy to assist you with an appropriate referral and, at your request, provide information to your new provider regarding your treatment.

I have read, understand and have discussed with my counselor each of the above policies and procedures. I agree to abide by these policies and authorize treatment to be provided to me (or my minor child).

I authorize release of information for the purpose of billing any third-party source for benefits, which I am eligible to receive.

I agree to pay fees agreed upon in this form. Any unpaid balance may be turned over for collection after 90 days and I agree to pay all costs of collection, including but not limited to reasonable attorney's fees.

I voluntarily consent to treatment and understand that it is my right to discontinue treatment at any time.

________________________________ ________________
Client Signature **Date**

________________________________ ________________
Parent/Legal Guardian (if minor) **Date**

________________________________ ________________
Counselor **Date**

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