ROBIN REINKE & ASSOCIATES COUNSELING

PERSONAL INFORMATION FORM

Date of Counseling/Seminar: _____

Your Full Name:_____ Your Spouse's Full Name: _____

Home Address (City, State, Zip Code): _____

_____

Spouse's address, if different: _____

Your Phone: _____ Spouse's Phone: _____ Home Phone: _____

Your Email: _____ Spouse's Email: _____

Your Date Of Birth :_____ Spouse's DOB:_____ Years Married:_____

Your Children's Names and Ages:_____

Please list previous marriages date and length of marriages:_____

Church you attend: _____ How often do you attend:_____

Would you like your Christian faith to be integrated in sessions? _____

Contact in case of an emergency (Name & Phone): _____

Have you *recently* thought of committing suicide or hurting someone else? _____

Please state medications each of you are *currently* taking and any medical or psychological diagnosis:_____

_____

Who was your prior therapist/psychiatrist and any diagnosis? _____

Please describe both your *current* physical health today: (e.g., Jet lagged? Depressed? Recovering from the flu, injury or surgery? Tired? Distracted? Hearing problems?) _____

_____

Is there anything you would like for your therapist to understand regarding you and your counseling goals: _____

_____

How did you hear about your therapist? Who referred you? _____

CONSENT FOR TREATMENT

You are here on your own free will & agree to counseling/intensive/seminar with Robin Reinke, LMFT or Rachelle Walton, APCC or Crystal St. John, LMFT. The purpose of counseling is to help you grow and deal with life challenges. To this end, we will talk about your personal life, past and relationships. It is important for you to be honest, but if you ever feel uncomfortable, please let your therapist know. All information is held in confidence, unless your life, or the life of someone else is abused or threatened, then someone will be contacted to ensure your own & other's safety. Be involved in your own growth. Counseling may leave you tired. Ensure self-care.

_____

Client's Signature Date

Robin Reinke & Associates Counseling

PAYMENT INFORMATION

Client Name: _____Date: _____ Counseling Dates: _____

☐ *Counseling* – Payment due at beginning of each session, checks payable to: "Robin Reinke & Associates Counseling or RR & Associates."

$180 per 50 minutes

Paid by: ☐ check #_____ ☐ credit card ☐ cash

☐ *Group* – Balance due on first day of group therapy Total Amount: $ _____

Deposit of $_____ Paid by: ☐ check #_____ ☐ credit card

Balance of $_____ Paid by: ☐ check #_____ ☐ credit card

Payment Type:

☐ Check - Check Amount: $_____ Check Number: _____

☐ Credit Card

☐ Cash $_____

CREDIT CARD INFORMATION:

Name as it appears on Credit Card: _____

Credit Card Number: _____

Credit Card Type: _____ Expiration Date:_____ Code on rear:_____

Address Credit Card is billed to:

Street: _____

City_____ State_____Zip_____

Signature of Card Holder _____ Date: _____

Regarding Insurance Coverage: Robin Reinke & Associates Counseling does not take insurance nor works with insurance companies. All sessions are to be paid up front by check or cash. When requested in writing, we will provide a detailed receipt with dates, times, amount paid, a diagnosis and CPT code for your insurance purposes. However, we currently do not submit to insurance companies on behalf of her clients, nor co-operate with insurance companies for reimbursements.

Office Use Only:

Session Dates: _____ Date Processed CC:_____ Amount:_____

Robin Reinke & Associates Counseling

RECEIPT OF FORMS

I have read and understood the forms/policies regarding:

i. Informed Consent for Treatment form
ii. HIPPA Privacy Policy and Practice form
iii. Fee of seminar/intensive/counseling and office practices form
iv. Payment practice and financial obligation for seminar/intensive/counseling
v. Communication via phone, email and text

I have had an opportunity to ask questions and have my concerns answered.

If I have concerns or complaints, I will resolve them with □ Robin Reinke or □ Rachelle Walton or □ Crystal St. John directly.

I also give □ Robin Reinke or □ Rachelle Walton or □ Crystal St. John permission to correspond with me via the email address given on my/our intake form. I understand email is not secure.

_____

Print Name Sign Name Date

_____

Print Name Sign Name Date

_____

Therapist Signature Date

Informed Consent for Treatment

Robin Reinke, MA, LMFT
Crystal St. John, MA, LMFT
Rachelle Walton, APCC (under supervision of Robin Reinke, LMFT)

Welcome to the therapeutic experience. It is an honor to be part of your growing process. Therapy is a very personal, difficult & potentially life changing experience. How much you benefit from therapy will largely depend on your own commitment to your growth. Your therapist will be a guide, a coach in your growth process. Your involvement will be of vital importance to your outcome. While there are no guarantees as to the outcome of your treatment, discuss with your therapist the potential risks, benefits and alternatives to the particular therapy you will receive. It is important that you understand your rights and obligations that relate to your therapy experience, so here are a few things you need to know that will assist you in beginning your process of therapy. Please feel free to discuss any questions you have concerning your treatment at any time. ***Please note that the Restoration Therapy Center does not have the facilities for childcare. Therefore, we request that you do not bring children to your session (unless they are involved in your counseling).***

About your therapists. . .

1. Robin Reinke is a Licensed Marriage and Family Therapist in the State of California. License MFC47310.
2. Rachelle Walton is an Associate Professional Clinical Counselor Intern in the State of California. Registration No. APCC7738. She is under weekly supervision with Robin Reinke, LMFT. The licensed therapist may also consult on your case for your benefit.
3. Crystal St. John is a Licensed Marriage and Family Therapist in the State of California. License MFC106856.

About your therapy sessions. . .

4. Standard therapy sessions (group/individual/family) will be 50 minutes in length. **Your session may be for 50 minutes, or 50-minute increments.** Standard fee is $180 per 50-minute increment. If different, your fee is: $_____ for each 50-minute increment.
5. Your sessions are for: _____ minutes for $_____

PLEASE HAVE YOUR CHECK READY AT THE BEGINNING OF EACH SESSION MADE TO "ROBIN REINKE". At your request, we can have a receipt ready at that time which you can submit to your insurance company for reimbursement since we do not take insurance.

6. Robin Reinke or Rachelle Walton or Crystal St. John may choose to use particular testing instruments to enhance the quality of treatment. An additional fee will be charged for any test administered at the cost of $180 an hour plus the cost of the testing material.
7. Hourly appointments must be cancelled 24 hours in advance, or 14 days for intensives. Otherwise a standard charge is due.
8. Phone calls will be returned within a 2-day period. If you have an emergency, please call 911 or a local crisis center. Telephone conversations exceeding 10 minutes may be billed on a prorated basis of $180 per 50 minutes.
9. Audio/Video taping of sessions may be done on occasion for therapeutic and/or professional purposes. These may be done only with your permission and written consent.
10. In some cases a co-therapist may work with Robin Reinke or Rachelle Walton or Crystal St. John. It will be at the therapist's discretion as to whether or not a co-therapist is present.
11. Because therapy is voluntary, you may begin or end your therapy at any time. It is customary to discuss your desire to terminate therapy at least one week in advance. If any issues come up or you are unhappy with any part of the therapeutic process, please discuss them first with your therapist.

About your confidentiality . . .

12. All therapy sessions are kept strictly confidential. This confidentiality includes your therapist's licensed accredited supervisor & co-therapist.
13. Confidentiality and privileged communication remain the rights of all clients according to state law. However there are limits to confidentiality, such as, when a therapist is subpoenaed by a court, or when it is mandated by law. The following are major areas where confidentiality is limited.

California state law mandates the reporting of incidences of child, elder and spousal abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of such abuse will need to be reported to the appropriate agency.

Some courts have held that if an individual intends to take harmful, dangerous, or criminal action against another human being, or against themselves, it is the counselor's duty to warn appropriate individuals of such intentions. Those warned may include a variety of persons such as: the person or family of the person who is likely to suffer the results of harmful behavior; the family of the client who intends to harm himself or someone else; associates or friends of those threatened or making threats; and law enforcement officials. Before informing anyone who should be warned, the counselor will take all possible steps to share that intention with the client.

NOTE: If you have a complaint about your therapist, you agree to first discuss your complaints with your therapist and all attempts to arbitrate will be made first. You agree to arbitration as a way of processing all complaints and concerns.

About communication. . .

14. **Emergency Treatment**. If you have a life threatening emergency, call 911 immediately. ROBIN REINKE & ASSOCIATES COUNSELING does not provide twenty-four hour coverage for emergency or crisis sessions. ROBIN REINKE & ASSOCIATES COUNSELING generally returns telephone calls within 24 to 48 hours of receiving them, so, if you are in a life threatening emergency, call 911 immediately.

15. **E-mail or Texting**. Other than scheduling appointments, unless otherwise agreed to by ROBIN REINKE & ASSOCIATES COUNSELING ROBIN REINKE & ASSOCIATES COUNSELING will not accept, review, or respond to E-mails or text messages from Patient or anyone acting on Patient's behalf. Patient agrees to limit E-mails and text messages to scheduling only.

About your finances. . .

16. I, the undersigned, fully understand that I am responsible for all payments due. I, the undersigned, have read and fully understand the responsibility of this contract. I have read this contract and have had my questions answered and have no concerns and herein agree to abide by all conditions above.

I have read and understood the above items, I have also asked any questions I may have:

_____

Your Printed Name Signature Date of Birth

_____

Therapist Signature Today's Date