**Client Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Soc. Sec #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Guardian Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to leave a message at any of the above numbers? (Circle) Y/N

Marital Status:

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Teacher/Grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main Contact person(s) and relationship(s)

I would like a 24-hour reminder for my appointments:  Yes  No thanks

Call  text  email

\*If yes, please provide phone# for reminder call or text\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications (include dosage)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Secondary Insurance**

Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Soc. Sec. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Soc. Sec. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent for Counseling:**

**Confidentiality:** Monty Shultz Counseling & Neurofeedback maintains a strict policy of confidentiality. All services are guided by the National Association of Social Workers and the licensing laws of the State of Nebraska. I understand that all information I disclose within sessions is confidential and not to be revealed to anyone outside of Monty Shultz Counseling & Neurofeedback.

1. When communication of my diagnosis and other clinical information to my insurance company is necessary for payment;
2. When I have given permission for information to be shared with another person;
3. When disclosure is required by law (e.g. when there is reasonable suspicion of abuse of children or adults; when there is a court order)
4. If I am under 19 years of age, my counselor may advise my parent(s) or legal guardian about developments that could significantly affect my health or well-being. In such situation(s), the specific content between my counselor and me will not be discussed, but my overall progress may be discussed in general terms; or
5. When I present an immediate risk of causing serious harm to another person.

**Supervision and Consulting**

Supervision is sometimes necessary for the purpose of providing the best possible service. Supervision may be required by your insurance company, office policy and/or licensing requirements. All staff at Monty Shultz Counseling & Neurofeedback are under the supervision of Monty Shultz LICSW #1219. At times the supervisor may be consulted about different cases. If your case is discussed with our supervisor it will be done without revealing any identifying information. All supervisors are bound by the same confidentiality standards as your therapist.

**Active Participation:**

Counseling is a mutual, collaborative process. You and your therapist will work together to develop goals for your therapy. You are responsible for making the effort to work on the problems or issues that concern you. Your therapist is committed to help you in this process.

**Risk/Benefits:**

No one can guarantee that counseling or counseling services (Neurofeedback) will produce certain results. There can be many benefits to participating in counseling. The benefits vary and can be maximized by active participation, honesty, and consistent attendance. There are also some risks associated with counseling services. The risks vary but can best be managed and minimized through open communication and reporting any changes that occur after of during

treatment. There is also the potential for dual relationships, which can be very common in rural settings. A dual relationship is any routine contact that occurs outside of therapy, such as attending the same church. If a dual relationship occurs, it is best to discuss this issue when it occurs to minimize the risk and assess its impact on the therapeutic relationship. Your direct honest feedback can help minimize risk. We can assure you that our counselors will use their professional skills, to the best of their ability, to address any concerns and help manage possible risk.

**Appointments:**

Services are by appointment only and generally last 45 minutes. The frequency of appointments will be determined by you and your therapist.

**Cancellations and No Shows:**

There is a 24-hour cancellation policy and all appointments not cancelled with 24 hour notice are subject to a late cancellation of fee that will not be covered by insurance. There is a no show policy and all appointments that you do not attend without calling to cancel are subject to a no show fee of $40.00 that will not be covered by insurance.

\_\_\_\_\_\_\_\_I agree to pay these fees, if incurred, I am aware that they will not be billed to my insurance company. I understand that I cannot be seen by my therapist again until these fees are paid or payment arrangements have been made.

**Fees and Financial Arrangements:**

Monty Shultz Counseling & Neurofeedback fees are: $150.00 for the initial appointment and individual sessions are $100.00 (45 minutes) or as reimbursed by insurance. Additional fees for services, if unknown, should be inquired about prior to the appointment. Often we call on your behalf to inquire about insurance benefits. Any information we receive from your insurance is not guarantee of their payment or your financial liability. We ask for payment at the time of service. If this does not work for you, please speak with your therapist to make arrangements for a payment plan. Any returned check will be charged a $25.00 fee. (Initial below).

\_\_\_\_\_\_ I am aware of Monty Shultz Counseling & Neurofeedback’s fees for treatment and I agree to pay the remainder of what my insurance does not cover. I agree to be responsible for payment of all services on my behalf or my dependents. I understand that if payment for services is not made, my therapist may stop treatment. I understand all services/materials are non-refundable.

**Electronic Communication (email/texting)**

Electronic communication is not a confidential means of communication. You may still choose to communicate electronically with Monty Shultz Counseling & Neurofeedback (as indicated above on preferred contact method) but you must acknowledge the risks (initial below).

x\_\_\_\_\_\_ I authorize Monty Shultz Counseling & Neurofeedback to contact me electronically regarding my appointments, as indicated above. I understand that electronic communication (email/text) is not a confidential means of communication.

x \_\_\_\_\_ I acknowledge that counseling will not be done electronically(email/text). If I send any informational electronically that is not in regards to scheduling.

x\_\_\_\_\_ I understand that any electronic correspondence may become part of my client record.

x\_\_\_\_\_\_ I understand that Monty Shultz Counseling & Neurofeedback cannot ensure that cannot ensure that electronic messages will be received or be promptly responded to. Therefore in case of emergency, I am encouraged to call 308-627-6119, or 911.

**Termination:**

Also, please be aware of the following conditions in regards to discontinuing therapy.

You may be discharged as a client:

1. If your therapist believes that they are unable to help you, because of the kind if issues present or because their skills or training may not be appropriate to serve you. You will be informed of this fact and referred to another therapist who may meet your needs.
2. If you have two consecutive “no shows” or same-day cancellations for appointments.
3. If you have not had and kept an appointment in our office in 6 consecutive weeks and this is not part of your treatment plan.
4. If you commit an act of violence toward, threaten, or harass any staff member of Monty Shultz Counseling & Neurofeedback, you may be immediately terminated from treatment.
5. If you are terminated from therapy for something other than completing the agreed-upon treatment plan, you will be given contact information for other sources of therapy. However, this is not a guarantee of further treatment.

*My signature below acknowledges that I have read, understand and agree to the above statements. I have received Monty Shultz Counseling & Neurefeedback’s privacy policies, understand my rights as a client and how my information may be used and disclosed. I understand and authorize supervision of my case, if necessary. I understand that my signature below is consent for treatment with Monty Shultz Counseling & Neurofeedback. I agree to actively participate in my counseling. I understand the risks and benefits associated with counseling and/or other services offered at Monty Shultz Counseling & Neurofeedback. I understand that if I have any questions regarding the above statements, associated risks or my privacy rights, I can talk to my therapist about any questions or contact Monty Shultz at 308-627-6119.*

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or guardian if minor Date

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness