ASPIRE
COUNSELING SERVICES

NEW CLIENT INFORMATION *(Please Print Clearly)*

Client Name: _____ _____ _____
Last First Birthdate Age

Spouse/Partner: _____

Address: _____
Street City State Zip

Current Employer: _____ Occupation: _____

Text/Cell Number: _____

Email Address: _____

REASON FOR COUNSELING

If you have ever received psychiatric or psychological help or counseling of any kind, please explain:

_____

_____

SUICIDAL RISK

Do you today, or have you at any time in your past felt like ending your life? □ Yes □ No
If yes, please explain:

_____

_____

Please rate your overall risk of suicide today (circle):

Extremely low risk: 1 2 3 4 5 :Extremely high risk
(will not kill self) (will kill self)

FINANCIAL RESPONSIBILITY

Name: _____
Last First

Relationship to You: _____

Address: _____
Street City State Zip

Phone: _____ Email: _____

Aspire Counseling Services

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I accept full responsibility for all fees due to professional services. I realize that any third-party billing is out of courtesy to me and does not transfer any financial responsibilities for unpaid services. I understand that 24 hours' notice is required to cancel or change an appointment, and that if 24 hours' notice is not given, I am responsible to pay the full amount of the session.

Client Signature: _____ **Date:** _____

How did you hear about us? _____

Were you referred? (Circle) YES or NO

If so, who referred you? _____

BIOPSYCHOSOCIAL HISTORY

Symptoms and Behaviors (Please be as specific as possible to any 'yes' responses)

Depressed Mood	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Appetite Disturbances	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Sleep Disturbances	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Change in Energy Level	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Decreased Concentration	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Anxiety	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Bingeing/Purging	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Feelings of Guilt	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Medical Conditions	□Yes	□ No	If "Yes", please describe:

PRESCRIPTION MEDICATIONS

(Please list all currently taking or have taken, the length of time and what they are prescribed for)

1.
2.
3.
4.

_____

_____

Emergency Contact Information

In the event of an emergency, please provide a contact person:

Name_____

Relationship_____**Phone**_____

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Client Information and Informed Consent

(Please read ALL information carefully and thoroughly.)

NOTE: If you are seeing Kim Buck, PhD, LPC at Aspire Counseling Services for couple's therapy, each person must fill out a separate set of forms for your first couple's session.

Welcome

Welcome, it takes courage to reach out for support and I look forward to supporting your healing journey. These forms contain information about Kim Buck PhD, LPC, doing business as Aspire Counseling Services [or ACS] professional counseling services and business policies. It is important that you review the following information before beginning your first session. Please feel free to ask any questions you may have about these policies; I will be happy to discuss them with you. There are multiple places where your signature will be required on the following forms.

Therapy Services – Risks and Benefits

The role of a licensed counselor is to assist you with challenges that may impact you emotionally. Counseling often involves discussing difficult aspects of your life. During our work together you may experience uncomfortable feelings such as sadness, guilt, shame, anger, or frustration. As a result of what comes out of your therapeutic work and the decisions you make, important relationships may be impacted or may end. Your journey in therapy may also lead to healthier relationships. If you ever have concerns about your therapy process, I encourage you to discuss this with me during your sessions so that we can collaborate together as you move forward.

Termination of Therapy

You may terminate therapy at any point. When our work comes to an end, I ask that you schedule at least one final session in order to review the work you have done. Occasionally clients return to therapy to process new challenges. If you decide to return in the future, please know that I have an open-door policy and I welcome the possibility of working together again. However, it will be at my clinical discretion and also dependent upon my availability. There is typically a wait of 2-4 weeks. If I am not able to see you immediately, I will be happy to add you to the waiting list, or to provide you with a referral to another competent therapist(s).

Your therapy records are closely protected and maintained for six (6) years after the last date of treatment. If you would like to obtain a copy of your treatment records, you can do so by sending a written request directly to Kim Buck, PhD, LPC.

Length of Therapy

Therapy is a process that is unique to each client and the challenges they are experiencing. Some issues can be worked on very effectively in a short period of time, and other challenges may take much longer. It can be difficult to predict exactly how long therapy will last so this is best discussed in your first session. You and I will put together a treatment plan and goals that you will be working toward. If you have questions regarding the length of treatment, please feel free to discuss this with me at the start and/or at any point during therapy.

Dual Therapy

It is unhelpful for two different therapists to provide counseling for the same client at the same time. Unless there is a compelling clinical reason, a crisis, or a specialized therapy treatment plan that we will be working on, I do not work with clients who are under the care of another therapist. If you are working with another therapist, please disclose this so that we can discuss next steps. If your therapist has referred you to ACS for specialized treatment (i.e. sex addiction, sex therapy, etc.), we will need to have a release on file from you in order to coordinate care with your primary therapist and collaborate on a clinical plan that best supports your process.

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Confidentiality
Therapy is best experienced in an atmosphere of trust. Thus, all therapy services are strictly confidential and may not be revealed to anyone without your written permission**. <u>There are exceptions to confidentially where disclosure is required by law (see below).</u>** Your confidentiality is very important to me. Should you request that I speak with another professional or person (i.e. doctors, former therapists, teachers, family, friends or anyone else outside the therapy room), you must first provide your signed written consent in order to do so and only after I determine if this is in the best interest of supporting your therapeutic process and progress. There are times when consulting with adjunct clinicians can be very helpful in providing you with the best possible care. As I am part of the executive team and supervisor at Family Strategies Counseling Center, I have the unique opportunity to utilize the vast experience and expertise of other clinicians.
In an effort to provide me with the best possible care, I hereby authorize my therapist, Kim Buck, PhD, LPC, to exchange confidential information regarding my treatment to other professional clinical staff at Family Strategies Counseling Center, LLC. Professional staff includes, but are not limited to, the Executive Directors, Clinical Supervisors, and other therapists who have expertise regarding specific clinical issues and treatment planning. I give this authorization of my own free will and have discussed any questions or concerns with my therapist. By signing this consent to exchange confidential information, I acknowledge that I have both read, understood and that I agree to all the terms of this release. I understand that my records are protected under Federal and State Confidentiality Regulations.

Client's Signature: _____ **Date:** _____

Legal Exceptions to Confidentiality
Your information is always confidential, with the exception of information relating to child abuse, suspected child abuse, elder abuse, dependent adult abuse, or intent to harm self or others, or **unless mandated by a court of law**. Legally, therapists are mandated reporters of abuse or intent to harm another. If you are suicidal or homicidal, your therapist at Aspire Counseling Services will take all reasonable steps to prevent harm to you or another.

A minor is defined as any person who is legally under the age of 18. I do not work with minors as clients; however, I am a mandated reporter of any sexual acts involving minors. This means that if I learn of **<u>any</u>** incident involving minors and illegal sexual activity or other types of abuse or neglect, **<u>I am legally required to report this to the proper authorities</u>**.

Please sign and date here if you understand the above stated limits of confidentiality and mandated reporting responsibilities of Kim Buck, PhD, LPC at Aspire Counseling Services, LLC.

Client's Signature: _____ **Date:** _____

Court Reports or Letters, Court Hearings
I, Kim Buck, PhD, LPC do not write legal letters or court reports on behalf of clients involving divorce, custody or other legal matters or lawsuits. I do not write letters pertaining to legal matters to any outside person (i.e. doctor, school, attorney, etc.) or agency regarding your treatment. If a special circumstance arrives where a letter is **required by court order,** it will require your written consent and will be billed to you at **$25.00** per page and **in addition to my hourly fee**.

As a general policy I, Kim Buck, PhD, LPC, am not a forensic specialist and prefer to not testify or participate in court proceedings on behalf of a client as that has the potential of changing the overall purpose and scope of my services. If you become involved in legal proceedings that requires mandated participation as your therapist, you will be expected to pay for all of my professional time, including preparation and transportation time and costs, even if called to testify by another party regarding your case. Because of the time involved and the interruption to my clinical work and compensation, you will be charged **$350.00** per hour for preparation, travel, and attendance at any legal proceeding on your behalf that you will be responsible for, a detailed accounting of time is available to you upon request. Court fees can be very expensive so please sign and date below to indicate that you understand your financial responsibility in covering these expenses should I be mandated to go to court for a legal issue you are involved in. Your therapist is not a court advocate or friend. A therapist must legally speak truthfully under oath.

Client's Signature: _____ **Date:** _____

Conjoint Sessions
On occasion, and only if it benefits the client's therapy goals, I may ask that a family member or significant other join you for a therapy session. It is important to note that this is done only on occasion and at my clinical discretion when it best serves the client. If the person joining the session is your significant other, this does not constitute as couples' therapy, rather it is as a support to your work, and/or a check-in session. Additionally, the third party (friend or significant other) is not joining the session for his or her own therapy, nor will I work with them as a therapist.

No Secrets Policy
Please note that with couples therapy the couple is the client (e.g. the treatment unit), **not the individuals**. As such I practice a **no-secrets policy** when conducting marital/couples' therapy. This means that confidentiality does not apply between the couple when one member of the treatment unit requests an individual session or contacts me outside of the therapy session to share a secret. Secrets do not include personal thoughts, feeling, desires, etc. of one of the parties, rather information that would be painful, harmful, or betraying to the other partner (i.e. affairs, financial betrayal, etc.). On occasion an individual session may be scheduled to assist in the overall therapy process to the treatment unit (e.g. the couple) and will be scheduled only when mutually agreed upon. Please understand that the majority of information shared in the individual sessions **will not** be held in confidence or secret in couple's sessions. I will encourage the person holding the secret to share the secret in the following session and will support the client in doing so. I also reserve the right to share or disclose information revealed by one partner in an individual session to the other partner or family members as deemed appropriate or necessary to support the treatment unit's overall treatment progress and goals.

Please Note: Kim Buck PhD, LPC, dba Aspire Counseling Services, LLC generally does not work with couples unless each individual has had prior individual therapy for a minimum of 3 months.

Sobriety Policy
I ask that all clients, couples, families, and group members arrive to therapy sober and not under the influence of drugs and/or alcohol. If I notice that you are intoxicated or substance impaired, the therapy session will be immediately terminated. Once you are safely home, I will reschedule the therapy session. **You will be charged your full fee for the session if you arrive intoxicated or impaired.**

Therapy Sessions and Fees
The fee for a standard therapy session at Aspire Counseling Services is **$250.00**. The standard therapy session is **45 minutes** in length. Therapy can be conducted in person in the office, via phone, or videoconference. It is understandable that occasionally you may be late. If you are late to your session, please understand that the session will not extend past your allotted time, nor will the time be made up at future sessions. Therapy sessions are paid via credit card or cash. Please fill out the credit card form included in this packet and bring with you to your first session. *If paying with cash, please bring the exact cash amount for your session fee.*

Fees are reviewed each year and may increase periodically. The increase will be discussed with the client, and a 30-day notice will be given prior to the increase. I am happy to answer any questions you may have about this fee agreement. Please understand that you have the right to terminate therapy at any point. If you have any questions regarding the fee policy, please do not sign until discussing with your therapist.

Appointments/Cancellations
Appointment cancellations made less than **24 hours** before the scheduled appointment will be charged the full agreed upon fee of **$250.00** for the session. If you do not show up for a scheduled appointment (that you have not called to cancel within 24 hours) you will be charged the full fee of **$250.00** for the session. You are responsible for keeping track and attending your sessions. *If you are sick or experiencing any symptoms of illness, I ask that you conduct your session via the phone or videoconference. If I am ill, I will extend the same consideration.*

Therapist Availability between Sessions
I am available to answer a short email regarding your therapy appointment times or therapy homework no more than twice per month without charging a fee. We will not process therapy issues via email unless you have been specifically instructed to do so as part of your treatment. If therapeutic services are required during non-business hours you will be charged at the rate of **$125.00** per every 15 minutes.

E-Therapy (when applicable)
E-therapy is the use of electronic media and information technologies to provide mental health services in different locations. There are limitations and risks associate with e-therapy, including inherent confidentiality risks of electronic communication and potential for technology failure. By signing below, you recognize that if there in an emergency and my therapist is unavailable, that I should call 9-1-1. I realize that if video is not available, my therapist will be asking me for identification. I will also be asked to provide my therapist with my physical location during the encounter, and verification that my setting provides for my confidentiality.

Physical Contact
Sexual contact is never acceptable in the therapeutic relationship. In some cultures, a supportive hug or other physical contact can be an expression of affection, or a greeting, or a goodbye. However, supportive physical contact can be also be misconstrued, triggering, or may interfere with the therapeutic relationship. As a general policy I do not offer supportive physical contact of any kind within the therapeutic relationship. Please understand, this is not an expression of judgment, dislike or dismissal, rather it is in the best interest of your clinical care based on a professional and therapeutic boundary. You always have the right to refuse physical contact at any time or for any reason.

Therapeutic Approach & Style
My goal as a therapist is to help people navigate through difficulties in their life and relationships while providing a safe place to heal, explore, develop insight, practice healthy coping tools, and integrate and take responsibility for their changes. My therapeutic approach is collaborative, honest, challenging, and direct with solid boundaries and empathy. I reflect, assist, encourage, and point out incongruent patterns around actions and words. I will formulate the therapeutic plan collaboratively with you based on your needs, presenting problems, and the goals you wish to achieve. I believe that each client has the potential for healing and change and is responsible for their choices and changes, and for meeting your therapy goals – I do not make guarantees for healing. I use a combination of cognitive behavioral, experiential, and client centered therapies with most clients.

AGREEMENT

- I have thoroughly read and fully understand the Informed Consent and the therapy policy pages of this document.
- I understand that I am financially responsible for all charges and fees incurred.
- I agree to honor the 24-hour cancellation policy.
- I understand the limits of confidentiality and all mandated reporting by my therapist.
- I understand that any disclosures of sexual activity or other abuse involving a minor are reportable under law.
- I agree to respect the boundaries of contact between sessions.
- I understand email and text are not appropriate forms of processing what is best discussed in session.
- I understand that emailing, texting and cell phone are not guaranteed as confidential.
- I understand and agree to the illness policy and will conduct sessions via phone if I am ill.
- I have answered all questions in full, truthfully and to the best of my knowledge.
- I have had all questions about this document answered and I am signing willingly.
- I authorize my therapist Kim Buck, PhD, LPC dba Aspire Counseling Services, LLC to provide psychotherapeutic services to myself, the client, by signing below:

Client's Name (printed): _____ Date: _____

Client's Signature: _____ Date: _____

Therapist's Name (printed): _____ Date: _____

Therapist's Signature: _____ Date: _____

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Client Credit Card Authorization Form

Client Name: _____

Date: _____

Individual Counseling Session Participants: By my signature below, I authorize ASPIRE COUNSELING SERVICES, LLC (Kim Buck, PhD, LPC) to debit/charge the account number I have specified below for the contracted amount. I understand that my account will be charged within three (3) business days of the appointment. Missed or cancelled appointment fees will also be assessed to my account.

☐ A third party is financially responsible for my account as previously arranged. Do not charge my card unless my bill is 30 days overdue and you have notified me.

Third Party Payer Name: _____
Phone: _____
Email: _____
Address: _____
Street City State Zip

DEBIT/CREDIT CARD AUTHORIZATION

Please circle the card type: VISA MasterCard Discover Card Amex

Name (as it appears on the card: _____

Credit Card #: _____ - _____ - _____ - _____

Expiration Date (MM/YY): _____

CVV # (on back of card): _____

Billing Address: _____
Street City State Zip

Cardholder Signature: _____

Phone Number: ☐ Mobile ☐ Work ☐ Home: _____

Email: _____

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Acknowledgement of Receipt of Privacy Practice Notice

By signing below, I hereby acknowledge receiving and reviewing the Aspire Counseling Services, LLC (Kim Buck, PhD, LPC) Notice of Privacy Practices and Limits of Confidentiality.

_____

Client's Name (print)

_____ _____

Signature of Client Date

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