Restoration Therapy Center

PERSONAL INFORMATION FORM

Date of First Session: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse/partner’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State & Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years Married:\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Your Children’s Names and Ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Church you attend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you attend:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like your Christian faith to be integrated into the sessions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who can I contact in case of an emergency (Name & Phone Number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you *recently* felt depressed, sad, alone or lost interest in life? Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your therapist/psychiatrist & what diagnosis have you been given? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your *current* physical health today: (e.g. Recovering from the flu, injury or surgery? Hearing problems? Disrupted sleep? Alcohol or any drug use?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your current situation and *counseling goals*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? Who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT FOR TREATMENT

You are here on your own free will & agree to counseling with your therapist. The purpose of counseling is to gain insight and grow as a person (although no guaranteed outcome are given). To this end, we will talk about your personal life, past and current experiences 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 possibly being abused or threatened, then someone will be contacted to ensure your own & other’s safety. Your therapist complies by the HIPAA regulations and will supply you with the full explanation of such upon request. You give full consent for psychotherapy treatment, payment and the implications of such. The counseling sessions may leave you tired. Take time to recuperate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print your Name Signature Date

Restoration Therapy Center

PAYMENT INFORMATION

Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of responsible party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Session: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Counseling session is at the standard rate of $120 per 50-minute increments.

\_\_\_\_\_\_If different, session rate is for: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per \_\_\_\_\_\_\_\_\_\_\_\_\_\_ minutes/hours.

\_\_\_\_\_\_Our office does not bill insurance nor receive payments from insurance companies. You are

responsible for the full session fee.

\_\_\_\_\_I will be paying for each session at the beginning of each session.

\_\_\_\_\_I will pay for my sessions by: \_\_\_\_Check \_\_\_\_Cash \_\_\_\_Money Order

Make check payable to : RTCSD

\_\_\_\_\_ (initial) I hereby agree to be responsible and to pay at the time of service for

each counseling session

Credit Card Information

Name on Card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date \_\_\_/\_\_\_\_ CVV # \_\_\_\_\_\_\_\_

Billing Zip code \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intensive Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ % due:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Processed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F/U #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Split:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bill Amt:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd Chair: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Restoration Therapy Center

***Charles Threatt III APCC #2754 supervised by Lance Ahl, LMFT 86028***

# Informed Consent for Treatment

*Welcome to the therapeutic/intensive 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.*

**About your therapist. . .**

1. Lance Ahl, has a BBA in management, a M.Div. and a MS in Marriage, and Family Therapy, he is a California LMFT #86028.

2. Charles Threatt III, has a B.A. in Christian Ministry, a MA in Educational Counseling +LPCC, he is a Registered Associate Professional Clinical Counselor APPC # 2754 Supervised by Lance Ahl, LMFT #86028

**About your therapy sessions. . .**

2. 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 $120 per 50-minute increment. If different, your fee is: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for each 50-minute increment.

3. Intensive sessions are for either: \_\_2-days ($2,850) \_\_2 ½-days ($3,550) \_\_3 -days ($3,850) \_\_\_\_ hours ($ 150 per 50 minute increment)

If different, the total cost for your intensive will be $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE HAVE YOUR CHECK READY AT THE BEGINNING OF EACH SESSION MADE TO “RTCSD”. 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.

4. Your therapist 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 $120 an hour plus the cost of the testing material.

5. Hourly appointments must be cancelled 24 hours in advance, or 14 days for intensives. Otherwise a full standard charge is due.

6. Phone calls will be returned within a 2-day period. Your therapist travels and may not return your call until available. If you have an emergency, please call 911 or a local crisis center. Telephone conversations exceeding 5 minutes may be billed on a prorated basis of $75 per 50 minutes.

7. 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.

8. In some cases a co-therapist may work with your therapist. It will be at therapist’s discretion as to whether or not a co-therapist is present.

9. 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 . . .**

10. All therapy sessions are kept strictly confidential. This confidentiality includes your therapist’s licensed accredited supervisor & co-therapist.

11. 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 your finances. . .**

12. 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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Husband/Wife Printed Name Signature Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature Today’s Date

Restoration Therapy Center

Charles Threatt III APCC #2754

supervised by E. Lance Ahl, LMFT #86028

RECEIPT OF FORMS

I have read and understood our office forms/policies regarding:

1. Informed Consent for Treatment form
2. HIPAA Privacy Policy and Practice form
3. Fee of seminar/intensive/counseling and office practices form
4. Payment practice and financial obligation for seminar/intensive/counseling
5. Communication via phone, email and text permission given
6. I understand that my counseling/seminar services are being provided by Charles Threatt III APCC 2754

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

If I have concerns or complaints, I will resolve them first with Charles Threatt III and our office directly.

I also give Charles Threatt III and our office permission to correspond with me via the email address given on my/our intake form. I understand email is not secure. I will inform you if I prefer not to be contacted via any of my phone/email provided on my intake form.

I also understand that Charles Threatt III speaks and writes in public forums for teaching and training purposes, and although they will not share my story in a manner that identifies me, stories they may tell may in some form resemble mine, due to the commonality of all human beings and couples.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Your Name Sign Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Husband/Wife Print Name Sign Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Charles Threatt III Date