

Individual
MARRIAGE & FAMILY

Enrichment

Client Contact Information

601 West Nifong Boulevard #1E
Columbia, MO 65203
(573)228-6702

Individual MARRIAGE & FAMILY Enrichment

A. Identification

Full name: _____ Date of birth: _____ Age: _____

By what name do you preferred to be called? _____

Home address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (mobile) _____

How do you prefer to be contacted? _____

Is it okay to leave a message on your phone? Yes No Email Address: _____

Please check here if you would NOT wish to be on our mailing list

B. Referral

How did you hear about my services? Please list your referral source: _____

May I please have your permission to thank the person who referred you? Yes No

C. Emergency contact

If an emergency arises and I need to reach someone close to you, whom should I call?

Name: _____ Phone: _____ Relationship: _____

D. Privacy Protection

I am dedicated to maintaining your privacy. In addition to professional ethical guidelines to protect your privacy, there are also laws that require I keep your information private. The details of these laws are outlined in the Notice of Privacy Protection. Generally, I will not release any information about you to another person unless I have express written permission from you, there is a medical emergency in which you require prompt medical care, or there is an order signed by a judge requiring me to release your record.

Missouri State law requires that counselors are mandated reporters of child and elder abuse and neglect. In addition, I have a legal and ethical obligation to protect you from harm. Therefore, I have the obligation to report to the authorities and take action when:

- 1) There is a reasonable suspicion of child or elder abuse or neglect.
- 2) There are credible threats of harm to oneself or to others and it is determined further evaluation is necessary.

By signing, you acknowledge receipt of the Notice of Privacy Protections and indicate that you have had the opportunity to have questions regarding your privacy answered.

Consent for Counseling Services

I _____ am consenting to receive counseling services from Individual, Marriage, & Family Enrichment LLC. Although other services may be required, it is currently anticipated these services will include:

- Individual Counseling, Couples Counseling, Family Counseling, Assessment, Evaluation,
- Other _____

I understand that while Individual, Marriage, & Family Enrichment counselors will use their best efforts to assist me, the nature of services of this kind is that there can be no assurances of results. Furthermore, I understand there are inherent risks in making personal life changes. I understand that I can discontinue services at any time.

Fees and Financial Policies

A. Fees

The fee for professional services from Individual, Marriage, and Family Enrichment is \$100/hour prorated to the nearest quarter hour. This includes individual, couples and family counseling as well as report preparation, letters on your behalf for legal matters or insurance companies, consultations with attorneys or other professionals, and phone calls of more than ten minutes duration.

B. Payment

Full payment is due at the end of each session. In order to keep costs down, payment is due at time of service and we do not carry outstanding balances. We accept checks, cash, or credit/debit cards. Please make checks out to "Individual, Marriage, and Family Enrichment LLC" or "IMFE". If the person receiving service is different from the person financially responsible, payment arrangements will be made in advance.

C. Missed appointments

If you miss an appointment without notification, or cancel with less than 24 hours notice, you will be billed for that session.

D. Insurance

We do not file insurance claims. We do not contract with insurance companies to provide any services. You may wish to submit receipts to receive reimbursement from your insurance provider. However, be aware that not all services will be covered.

Please specify if you will be submitting your receipts for reimbursement. Insurance companies will require additional information, including the diagnosis of a mental disorder, and may require detailed background information including substance abuse history.

Signature

Date

If Person Responsible for Fees Is Different than Person Receiving Services Please Complete:

Name of person responsible: _____ Phone: _____

Address: _____

Street

City

State

Zip Code

Payment arrangements will be:

I understand and agree to the financial arrangements.

Signature: _____ Date: _____