**Instructions:**

**Please read the attached forms and bring the completed questionnaire for each person to our first session. This information is needed prior to the session.**

**DEBORAH H. WEIR, PhD, NCC**

# LICENSED MENTAL HEALTH COUNSELOR #MH 4055 (FL)

**LICENSED PROFESSIONAL COUNSELOR #7547 (NC)**

# CERTIFIED SEX THERAPIST

### *CONFIDENTIAL CLIENT QUESTIONNAIRE*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**↑Name Social Security # Today’s Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**↑Address City State Zip**

**Phone: Home (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to call? Y N Work (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to call? Y N**

**Cell (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to call? Y N E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to use? Y N**

**Relationship status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Years\_\_\_\_\_\_\_\_ Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer/Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Years\_\_\_\_\_\_**

**Birth place\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Religious orientation (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Currently active? \_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you have received counseling services in the past, please list dates and purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list any health problems you have now\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list all medications (prescribed or over-the-counter) which you take: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been hospitalized for mental health reasons? YES NO When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Family & significant others: Name Age* Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Still married to each other? \_\_\_\_\_\_\_\_\_\_**

**Name & age of spouse/partner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First name & age of sisters & brothers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First name & age of children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle any of the following which are currently problems for you:**

**Depression Fears Sleeping**

**Stress Sexual problems Suicidal thoughts**

**Self-esteem Panic Guilt**

**Communicating Alcohol/drug use Eating problems**

**Anger Terminal illness Thoughts**

**Anxiety Memory/concentration Perfectionism**

**Fearing failure Making decisions Death of loved one**

**Health Relationship problems Gay/lesbian/bisexual/transgender**

**Obsession/Compulsion Legal matters Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has any *biological* family member ever had a drinking or drug problem, depression, bi-polar (manic depression) nervous breakdown, mental disorder, or attempted suicide? Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Briefly describe your reasons for seeking counseling at this time:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your average *weekly* intake of alcoholic drinks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_per week**

**Any recent increase?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**At the time of your life when you were drinking the most, how much did you drink *weekly*?\_\_\_\_\_\_\_\_\_\_**

**List any other kinds of recreational drugs you sometimes use, or have used in the past, legal or illegal:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who referred you to me for counseling?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I thank this person? \_\_\_\_\_\_\_\_\_**

**Who may I contact in case of emergency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DEBORAH H. WEIR, PhD, NCC**

# LICENSED MENTAL HEALTH COUNSELOR #MH 4055 (FL, issued 12/96)

**LICENSED PROFESSIONAL COUNSELOR #7547 (NC, issued 9/09)**

**Certified Hypnotherapist**

# Certified Sex Therapist

## INFORMATION FOR CLIENTS

Thank you for using my counseling services. My goal is to provide a range of cost-effective and solution-oriented counseling services to people like you who are seeking to improve the quality of their lives and relationships. From the start, I want to make this experience as convenient as possible for you. I am happy to provide this intake paperwork so you don’t have to do it in my waiting room. Please read it, fill it out at your convenience, and bring it with you to our scheduled meeting. If you are coming with a spouse or partner, each of you will need to bring your own forms.

If something happens and you cannot make the appointment, I would appreciate it if you would call me at (828) 575-4139 or (828) 505-0877. I understand that changes are often necessary, and I would be happy to reschedule our appointment.

Most people who come to counseling for the first time are a little uncertain about what they will be doing, what is expected of them, and what the rights and responsibilities of both counselor and client are. I am providing this form to help you understand my services and to answer some questions you might have. Please discuss with me any questions you might have about any aspect of the counseling process.

I am in the private practice of counseling. I also rent office space with other psychotherapists who share the waiting room with me. However, our practices are completely unrelated to each other and we share no client information.

MESSAGES. I do not accept phone calls while in session. My voice mail or email [debweir@weirpartners.net](mailto:debweir@weirpartners.net) is always available to you. I have no secretary and I make my own appointments. Nearly always, your call will be returned the same day.

APPOINTMENTS. Counseling sessions are generally 45-50 minutes. Appointments end promptly at the time agreed, even if you arrive late, so I can prepare for my next client. The first appointment may be longer. We will arrange appointments at your convenience. I may even prepare my office and files solely to see you. If you need to cancel an appointment, *please* give me at least 24 hours notice. Failure to provide notice generally means that some other person is not able to use the appointment time that is reserved for you. *You will be responsible for payment for appointments that are not canceled 24 hours in advance unless you have experienced circumstances which both you and I would define as an emergency.* By the same token, *if I cancel a session without 24 hours notice, and we would not define it as an emergency, your next session will be free of charge.*

TREATMENT. You are encouraged to obtain knowledge of the procedures, goals, and possible side effects of therapy. Your maximum benefit is our only legitimate goal. Counseling can be tremendously beneficial, and, at the same time, there are some risks. Risks may include the experience of unwanted feelings, including sadness, anger, fear, guilt or anxiety. These feelings are natural and normal, and are an important part of the counseling process. While in therapy, some people make major life decisions, including new commitments or separations, changes in relationships, and changes in employment settings and lifestyles. These decisions are a legitimate outcome of the counseling experience when the client calls into question many held beliefs and values. Because I am a Board Certified Sex Therapist and a Board Certified Hypnotherapist, I may utilize various related techniques in our work together. I am always willing to discuss any of your expectations, concerns, problems, or possible negative side effects of our work together.

It is important to understand that the type of life improvement you are seeking does not simply occur by spending an hour a week with a counselor. Modern "solution-oriented therapy" techniques for effective and lasting results require an investment on your part.

The following is a list of my services and methods:

**Areas of Service:**

* **Depression Management**: Relief from malaise, concentration problems, negative outlook, low motivation, helplessness, and other symptoms of depression.
* **Self-Esteem Enhancement**: Reversal of negative thoughts and self-destructive behaviors that are barriers to feeling good.
* **Anxiety Management**: Relief from trauma, panic, phobias, obsessions, stress, and other situations causing hard-to-control anxiety.
* **Weight Control**: Strategies in the areas of fitness, nutrition, and self-regard that will result in a healthier body and self-image.
* **Body Image Enhancement**: Relief from self-loathing and relationship issues resulting from a negative regard for the body.
* **Smoking Cessation**: Strategies to finally stop the nasty habit that isn’t *cool* anymore.
* **Relationship Therapy**: Couples therapy including communication training, issues resolution, and sex therapy. Individual therapy including relationship search, starting over after a painful relationship loss, and coaching for a problem relationship.
* **Women’s Sex Therapy**: Education and therapy for women’s sex issues, such as low libido, sex aversion, orgasm dysfunction, painful intercourse, and hormonal changes.
* **Chronic Disease Management:** Lifestyle coaching, wellness techniques, and management of side effects related to disease.
* **Weight Management:** Hypnotherapy and cognitive-behavioral therapy directed toward enhanced weight loss and maintenance of lifestyle changes.

**Methods:** Used in various combinations, depending on the problem and desires of a particular client.

* **Insight-oriented therapy:** Exploration of earlier and/or recent troubling events and the feeling and meaning attached to them to help increase peace and understanding.
* **Hypnotherapy:** Eyes-open techniques, neuro-linquistic programming, formal trance, self-hypnosis/meditation instruction, and individualized recorded audiotapes to help elevate personal consciousness and gain relief of troubling perceptions.
* **Dream Interpretation:**  Deciphering symbolic messages from the unconscious contained in nighttime dreaming for insight and guidance in personal issues.
* **Cognitive-Behavioral Approach:** Direct focus on changing thoughts, beliefs, and actions that are contributing to depression, anxiety, and poor coping.
* **Values Clarification:** The identification of “what’s important” as an impetus for change.
* **Personal Coaching:** Goal-setting and action planning for lifestyle changes, career enhancement, and balance.
* **Psycho-education:** Use of educational handouts, videos, and verbal instruction for various mental health issues.
* **Mars-Venus Orientation:** Understanding of the difference in feminine and masculine energy and how it reflects in relationship dynamics, based primarily on the work of Dr. John Gray.
* **Communication Training:** Instruction and practice of intimate communication strategies that will serve to enhance the loving aspect of relationships while creating safety and intimacy.
* **Expressive Therapy:** Use of creative media such as artwork, writing, active imagination, and such to enhance insight and personal growth.
* **Individual Nature Connection:** Exercises carried out in nature to utilize the natural healing power of the wilderness environment.
* **Group Therapy:** Held periodically with various themes, such as body image support, self-esteem, relationship support, and general issues.
* **Wilderness Seminars:** Held periodically as a weekend retreat for nature-lovers.
* **Community Resources:**  Assistance in locating support groups, alternative therapies, specialists, in-patient treatment facilities, etc.

GOALS. The more actively involved in counseling you are, the more effective counseling will be for you. At the outset, we will establish goals for your therapy. As indicated by your signature below, you agree to work toward these goals in your everyday life, and to use your sessions for guidance, understanding, and training as to how best to achieve these goals. Also, we will periodically review your goals, because life is a process and goals often change. And there is no guarantee that the goals will be attained. You will benefit most if you:

1. Make your counseling goals a part of your everyday life,
2. Commit to continuing counseling until your goals have been met, and
3. Work between sessions to deepen your understanding and put into effect the knowledge and techniques you are gaining from therapy.

**NOTICE OF PRIVACY PRACTICES (HIPPA)**

THIS **NOTICE OF PRIVACY PRACTICES** DESCRIBES HOW HEALTH, MEDICAL, & PSYCHOTHERAPY INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Disclosure - If you are covered by insurance or an EAP, information about your diagnosis and treatment may be given to the insurance company, your employer, their agent, or a national insurance database for treatment, payment, and health care operations. I am permitted or required to use or disclose protected health information for other purposes without your written consent or authorization, such as when there is danger of actual physical harm to yourself or someone else, when physical or sexual abuse or neglect of a specific minor child or elderly person becomes known. In legal cases, a judge may issue a court order for me to release client information or records. If you are seeing me with your relationship or family partner, information may be discussed openly with them. Other uses and disclosures will be made only with your written authorization and you may revoke such authorization in writing any time in the future.

1. Patient’s Rights - Protected health information (PHI) consists of your personal counseling records except for psychotherapy notes. With respect to PHI, you have the following rights:
   1. The right to request restrictions on certain uses and disclosures of PHI, such as to ask me not to give any information to your family. I am not required to agree to a requested restriction. If we cannot agree on appropriate restrictions, you are free to go elsewhere; however, once we agree to restrictions, we must abide by them;
   2. The right to receive confidential communications of PHI;
   3. The right to inspect and copy, at your cost, PHI;
   4. The right to amend PHI;
   5. The right to receive an accounting of disclosures of PHI to others;
   6. The right to receive the notice electronically or to obtain a paper copy of the notice upon request.
2. Practice Responsibilities – I am required by law to maintain the privacy of PHI and to provide individuals with notice of my legal duties and privacy practices with respect to PHI; I am required to abide by the terms of the notice currently in effect. In case I may wish to make a change in my privacy policies, I reserve the right to change the terms of your notice and to make the new notice provisions effective for all PHI that you maintain. I will provide you with a revised notice by mail to your latest known address.
3. Complaints - Individuals may complain to the practice and to the Secretary of HHS if they believe their privacy rights have been violated. You may file a complaint with the practice by mail to my office as described below, and you will not be retaliated against for filing a complaint. Or you may contact the Office for Civil Rights in Washington, DC. In FL, please contact the Florida Dept. of Consumer Health Unit at www.floridahealth.gov. In NC, please contact the North Carolina Board of Licensed Professional Counselors (NCBLPC), P.O. Box 77819, Greensboro, NC 27417, Ph: 336-217-9450, fax: 336-217-9450, email: complaints@ncblpc.org.
4. Contact - The person to contact for further privacy related information is (mailing address):

Deborah Weir, PhD, LMHC

189 Jordan Rd.

Swannanoa, NC 28778

1. Effective Date – The effective date is August 1, 2014.

CLIENTS WHO ARE DEPENDENTS. If you are requesting services as a guardian or parent, the same general practice applies with regard to confidentiality as outlined above. It is essential that your dependent have complete trust in confidentiality with me. However, as a parent or guardian, you have the right and responsibility to question and understand the nature of therapeutic activities and the progress of your dependent. I must use clinical discretion as to what is appropriate disclosure. In general, specific information will only be released with the dependent's consent, but I will discuss progress and your partici­pation in treatment.

FEES. My fees are set in accordance with usual and customary fees. They cover time for other activities on your behalf, such as research, record keeping, and preparation. I do charge for telephone calls or other activities longer than 10 minutes. I accept payment by credit card, cash or check, payable to Deborah H. Weir, PhD. You are encouraged to discuss fees at any time. If covered by insurance, your signature below authorizes payment directly to me. Please note that insurance companies typically require assignment of a diagnosis, and that this will become a part of your healthcare record. Because of the multitude of insurance companies and policy types, I am unable to assure insurance coverage. If insurance coverage is declined or if you miss an appointment without advanced notice, you agree to be responsible for the full fee. Please make your check out before the session, so that our time may be spent on your issues. Fees for legal involvement and court time are approximately 150% of standard fees.

My standard full fee is $125/hr.

My sliding scale based on income is as follows:

Individual $40,000 - $50,000 per year: $100/hr

Couple $55,000 - $65,000 per year: $100/hr

Individual $30,000 - $40,000 per year: $ 90/hr

Couple $40,000 - $55,000 per year: $ 90/hr

Individual $20,000 - $30,000 per year: $ 80/hr

Couple $30,000 - $40,000 per year: $ 80/hr

Individual $0 - $ 20,000per year: $ 65/hr

Couple $0 - $30,000 per year: $ 65/hr

Student rate (Individual, unmarried): $ 50/hr

Our agreed upon fee for service is \_(To be discussed at our first meeting)\_\_\_\_\_\_\_\_\_\_.

Please visit my website at www.WeirPartners.net for full bio, contact information, and list of services.

**EDUCATION:**

Master of Arts in Counselor Education, 1993

University of South Florida

Tampa, FL

Additional studies: 2002, Achieved PhD in Clinical Sexology through the American Academy of Clinical Sexologists, Orlando, FL Dissertation: *An Odyssey of Sexual/Gender Evolution: An Autoethnographical Study of the United States from the 1950s to the Present*

***I HAVE READ AND UNDERSTAND ALL OF THE ABOVE “INFORMATION FOR CLIENTS” AND AGREE TO THE CONDITIONS AND CONFIDENTIALITY LIMITS. I AGREE TO WORK TOWARD MY GOALS BETWEEN MEETINGS. I AGREE TO BE FULLY RESPONSIBLE FOR PAYMENT FOR COUNSELING SERVICES AND FOR MISSED APPOINTMENTS THAT ARE NOT CANCELED WITH 24 HOURS NOTICE. (IF COVERED BY INSURANCE, THE AMOUNT FOR A MISSED APPOINTMENT IS THE CO-PAY PLUS THE AMOUNT INSURANCE WOULD OTHERWISE PAY.)***

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

#### Client Signature Date

#### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature Date