CLIENT INFORMATION

Please Note: The information you provide here is protected as confidential information

Name: _____ Date: _____

Birth Date:_____ Age: _____

Address:_____

City/State/Zip:_____

Phone Hm:_____ May we leave a message? □ Yes □ No

Phone Cell:_____ May we leave a message? □ Yes □ No

Email:_____

**** Please note: Email correspondence is not considered to be a confidential medium of communication.***

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced

Emergency Contact:_____
(Name) (Phone No.)

Referral Source:_____

Please list any children or significant family members & their age:

Name	Relationship	Age

Are you under the care of a physician/psychiatrist?: □ Yes □ No

If Yes, name(s) and contact number(s): _____

_____

If you have been diagnosed by him/her for any condition(s), please list:

_____

Current Medication (s):_____

_____

What significant stressful events have you experienced recently that may have contributed to your current decision to seek psychotherapy?

_____

_____

_____

If there is one thing you would like to get out of therapy, what would that be?

_____

_____

_____

Comments/Special Circumstances

_____

_____

_____

_____

LIMITS OF CONFIDENTIALITY

All therapy sessions are considered to be confidential. Records about a client (verbal and/or written) cannot be shared with another party without the written consent of the client or the client's legal guardian. Although confidentiality is one of our primary concerns, we follow Texas law that mandates reporting in certain situations. In most cases, when such a situation needs to be reported, the therapist will work with you to determine the most helpful way to do so.

Exceptions when it is required to report the information to the appropriate legal authorities:

Abuse of Children and Vulnerable Adults
If a client states or suggests:

- He or she is abusing or has recently abused a child or a vulnerable adult
- A child or a vulnerable adult is in danger of abuse

Abuse of Self or of another Person
If a client states or threatens

- He or she will hurt themselves – measures will be taken to enlist cooperation. Further measures may be taken without their permission in order to ensure their safety.
- He or she will hurt another person

Abuse by Previous Therapist
If a client states or suggests

- He or she has been abused by a previous therapist/counselor

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information requested may include type/dates of services, diagnosis, treatment plan, description/progress of therapy, and case notes/summaries.

Subpoenas or Legal Matters
Exceptions to confidentiality also occur when clinical records are subpoenaed as part of a legal matter. Please advise your therapist if you are involved in a lawsuit.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature **Today's Date:**

_____

Witness

Dharma Wellness

CANCELLATION AND BILLING POLICY

We cannot use the time for another client if you fail to cancel or change a scheduled session. Consequently, you will be billed for the entire session for any missed appointments.

A full fee is charged for cancellations with less than a 24 hour notice, unless due to an illness or an emergency. An invoice will be mailed directly to all clients who do not show up for or cancel an appointment without adequate notice.

Please note that your insurance company cannot be billed for any missed appointments.

Dharma Integrative Psychotherapy & Wellness, PLLC will be responsible for the filing of insurance claims. Clients will be responsible for the co-payment or deductible for each visit, when applicable. If you wish to use out-of-network behavioral health benefits, we will be happy to assist you in any way we can.

Dharma Integrative Psychotherapy & Wellness, PLLC requires valid credit card information on file for all clients. A client can also use this as a form of payment/auto-payment for his or her session or in the event of any missed appointments.

Please don't hesitate to ask any questions regarding our policies and procedures. We thank you for your consideration regarding this important matter.

Your signature below indicates your agreement to adhere to the policies and procedures of the Dharma Integrative Psychotherapy & Wellness PLLC.

_____

Client Signature

_____

Today's Date

INFORMED CONSENT FOR THERAPY

I understand that therapy begins with an evaluation of my situation, past and present. While the therapist is deciding whether she is the appropriate therapist for me, I will decide whether I wish to begin therapy as well. I understand that due to the commitment of time and money, & the potential impact on myself and others, it is important to make an informed choice.

I have read and understood the potential limits of confidentiality, including those imposed by the policies of the Dharma Integrative Psychotherapy & Wellness, PLLC and by TX State law, and I have received a copy to keep. I have been given the opportunity to ask questions and discuss confidentiality and disclosure policies with my therapist. I understand all policies as described on the Client Information Form and accept them as conditions for entering into therapy with Dharma Integrative Psychotherapy & Wellness, PLLC.

I agree to share responsibility with my therapist for the therapy process, including goal setting and termination. By entering into therapy, I accept and understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. I understand that the changes made will have an impact on myself and on others around me. I accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by my therapist at the Dharma Integrative Psychotherapy & Wellness, PLLC. I am aware that I may stop my treatment at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment. I understand that I may lose other services or have to deal with other problems if I stop treatment. I am also aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive.

By signing below, I agree to accept mental health services from **Rabia Ilahi, MA, LMFT** at Dharma Integrative Psychotherapy & Wellness, PLLC at _____ per hour and accept full responsibility for payment.

_____ _____

Signature **Date**

I, **Rabia Ilahi, MA, LMFT**, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Therapist **Date**