Darla Gale Counseling
Marriage and Family Therapist, Inc.
Phone: 916-397-9039 Fax: 916-471-0559
DarlaGaleCounseling@gmail.com

Counseling Application/Intake Form

Date_____ Referred By:_____

This application is for: ☐ **Marriage and/or Couples Counseling** ☐ **Court-Ordered/Reunification**
☐ **Individual Female** ☐ **Individual Male** ☐ **Parent and Child** ☐ **Family** ☐ **Other**

Client #1 _____ Date of Birth _____
#1 Address _____ City _____ State _____ Zip _____
#1 Phone (H) (C) _____ Email _____
#1 Administrative Sex_____ Gender Identification_____ Sexual Orientation_____ Race/Ethnicity _____

Client #2 _____ Date of Birth _____
#2 Address _____ City _____ State _____ Zip _____
#2 Phone (H) (C) _____ Email _____
#1 Administrative Sex_____ Gender Identification_____ Sexual Orientation_____ Race/Ethnicity _____

Child _____ Date of Birth _____
Child _____ Date of Birth _____
Child _____ Date of Birth _____

Marital Status
☐ Single ☐ Living together for_____years ☐ Married for _____years
☐ Divorced for_____years ☐ Widowed for _____years

Your Employer
Occupation _____ Work #_____
Spouses Employer _____

Emergency Contact: Name _____ Phone_____
Relationship_____

Counseling History Have you ever consulted a counselor, psychotherapist, or psychiatrist before?
☐ Yes ☐ No Name of therapist:_____
Dates seen - from __/__/__ thru __/__/__ Reason:_____

_____

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Medical History:

Have you taken, or are you now taking, any prescription medications for mental health issues?

☐ Yes ☐ No

What prescriptions?_____

For how long? _____

Prescribed by whom and for what conditions?_____

Please give a brief summary of the **specific reason** you are seeking counseling at this time. Be assured this information is confidential and will be used only for the purpose of assigning you to the appropriate counselor.

_____

_____

_____

_____

I would like to request a handicap accessible room and I cannot walk upstairs. ☐ Yes ☐ No

I give permission to Darla Gale Counseling, Marriage and Family Therapist, Inc. to send me emails, announcements, and updates regarding additional services and products related to mental health.

☐ Yes ☐ No

Please Check Any That Apply (Days and Times – We are open 7 days a week including evenings)

Monday_____ Tuesday_____ Wednesday_____ Thursday_____ Friday_____ Saturday_____ Sunday_____

_____

Choose your payment option below:

☐ **I am ABLE to pay the clinical counseling fee of $150/session.**

☐ **I need court-ordered therapy at the rate of $150/session.**

☐ **I need Couples and/or Family Counseling at the rate of $150/session.**

☐ **I would like Brain Spotting or EMDR sessions at the rate of $150/session.**

☐ **I am UNABLE to pay the above fee and wish to use the SLIDING FEE SCALE based on my gross monthly income (*court-ordered therapy, couples, families, brain spotting, and EMDR not included*).**
The sliding scale fee I am able to pay is _____

Print Name: _____ **Signature** _____ **Date** _____

Print Name: _____ **Signature** _____ **Date** _____

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Informed Consent

Welcome
Thank you for choosing Kimberly Goehring as your Registered Associate Marriage and Family Therapist. I look forward to working with you! This document is intended to provide important information to you regarding your treatment, confidentiality and your rights and responsibilities. Please read the entire document carefully and be sure to ask any questions you may have regarding its contents.

Information About Your Therapist
I am a Registered Associate Marriage and Family Therapist, AMFT # 139877 and I have experience working with adults, adolescents, children, couples, and families. I believe the therapeutic relationship is the most crucial factor in achieving a successful counseling experience and I will provide a safe and supportive environment where we will learn from each other. I am confident that each unique individual has the capacity within themselves to heal, change, and grow. I approach therapy with a solution focused, strength-based and trauma informed background. My therapeutic approach utilizes Attachment Theory, Cognitive Behavior Therapy (CBT), Internal Family Systems (IFS), and Dialetical Behavior Therapy (DBT). I have experience working with a myriad of issues including depression, anxiety, sexual abuse, eating disorders, post-traumatic stress disorder (PTSD), addiction, borderline-personality disorder, infidelity, grief, and trauma. I would be honored to guide you through your healing journey and provide you with the space and tools to overcome life's challenges.

Confidentiality

What is revealed in this setting is protected by professional and ethical standards. All material is confidential and not released without written consent except information related to suspected child abuse, elder abuse, dependent abuse, threatened homicide or suicide. **If you are in immediate danger to yourself or others, please call 911. You may also call or text the National Suicide Prevention Hotline at 988, or chat at 988LifeLine.org**

___ **Please initial here** to acknowledge you understand.

Client Litigation

I will not voluntarily participate in any litigation, or custody dispute in which you, your representative and another individual, or entity, are parties. I have a strict policy of not communicating with your attorney and I will generally not write or sign letters, reports, declarations, or affidavits to be used in regard to your legal matter. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse Darla Gale Counseling Marriage and Family Therapist, Inc. for any time spent for preparation, travel, or other time in which we have made ourselves available for such an appearance at our regular hourly rate of $150.00.

___ **Please initial here** to acknowledge you understand.

Psychotherapist – Client Privilege

Typically, the client is the holder of the psychotherapist-client privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert psychotherapist–client privilege on your behalf until instructed, in writing, to do otherwise by you or your representative.

___ **Please initial here** to acknowledge you understand.

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Records and Record Keeping

I will produce notes and records regarding your treatment. These notes constitute our clinical and business records, which by law, I am required to maintain. Such records are the property of Darla Gale Counseling, Marriage and Family Therapist, Inc. I will not alter our normal record-keeping process at your request. Should you request a copy of our records, such a request must be made in writing. I reserve the right, under California law, to provide you with a treatment summary in lieu of actual records.

Upheal is the platform some of our therapists use to transcribe and to write required progress notes. If using Upheal, the therapist will have signed a Business Associate Agreement (BAA) to protect data that is shared with Upheal. Under the BAA, Upheal adheres to regulations such as the HIPAA Security Rule and Privacy Rule. This ensures that electronic health information (ePHI) is safeguarded through appropriate administrative, physical, and technical measures, ensuring its confidentiality, integrity, and security. You can learn more about Upheal and its privacy practices at www.upheal.io/privacy

____ **Please initial here** to acknowledge you understand.

Electronic Communication & Confidentiality

Your therapist will maintain contact with you via text, email, or other electronic means. Although I cannot be certain this information will not be intercepted, I will do my part to protect your confidentiality.

____ **Please initial here** if you understand the risks of communicating with your counselor by electronic means, and still wish to do so. Your initials indicate you understand the risk, and consent to electronic communication with your counselor, **including appointment confirmations**.

Counselors

Counseling is provided by counselors who are in training to become Licensed Marriage and Family Therapists (LMFT) or Licensed Professional Clinical Counselors (LPCC). They are supervised by Darla Gale, LMFT #92413, a Licensed Marriage and Family Therapist. During these supervision meetings, your information may be discussed between counselors and with the supervisor to gain understanding and build skill and knowledge related to marriage and family therapy. The Supervisor may, at times, record your session for the purpose of training and education only. We value your confidentiality and will make every effort to only share unidentifiable information. The supervisor may reach out to you to check on your experience with your therapist to ensure the best possible treatment.

____ **Please initial here** to acknowledge you understand.

Fees and Payment

Darla Gale Counseling, Marriage and Family Therapist, Inc. accepts MEDI-CAL FFS and California Victims of Crime insurance. To begin treatment, authorization from your insurance company is required. For all other services, fees are offered on a sliding scale and are payable in cash, check, and credit cards, including health savings account cards. If an insurance company does not pay Darla Gale Counseling within 60 days after the first session, we will pause treatment to avoid accumulating unpaid

bills. Sessions will resume once payments from insurance companies are up to date.

Payment of fees will be due at the beginning of each session. There is a $25 fee for any returned checks. At times, a fee may be waived based on our ability to receive grants or in an unlikely event of a crisis where a client is a danger to themselves or someone else and they need increased sessions, or at the discretion of the Supervisor. If for some reason the payment was not provided or did not go through, you will need to make payment for that session before scheduling another one. Clients are expected to pay for services at the time the services are rendered. If you have out-of-network benefits, we can supply a Superbill for you to file with your insurance. However, you (not your insurance company) are responsible for full payment of fees. Darla Gale Counseling, Marriage and Family Therapist, Inc. cannot guarantee reimbursement from your insurance company.

From time to time, the therapist may engage in telephone contact with you for purposes other than scheduling sessions. You are responsible for payment of the agreed-upon session fee (on a pro-rata basis) for any telephone calls lasting longer than 10 minutes and/or writing emails or text messages where the therapist spends longer than 10 minutes. In addition, from time to time, the therapist may engage in telephone contact with third parties at your request and with your advance written authorization. You are responsible for payment of the agreed-upon session fee (on a pro-rata basis) for any telephone calls longer than 10 minutes.

____**Please initial here** to acknowledge you understand.

Cancellations, Rescheduling, and No Shows

Cancellations must be made 24 hours in advance. If an appointment is canceled or missed without 24 hours of notice, you will be charged your usual session fee for that missed session. **If three sessions are canceled within a 3-month period (with or without a 24-hour notice), we may terminate treatment.**

____**Please initial here** to acknowledge you understand.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depends on the specifics of your treatment plan and your progress. We will collaborate on the termination of your therapy and discuss a plan as you approach the completion of your goals. You may discontinue therapy at any time and either of us may elect to initiate a discussion of treatment alternatives including referral, changing your treatment plan, or termination. The therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include but are not limited to untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client needs being outside the therapist's scope of competence or practice, or patient is not making adequate progress in therapy.

Your Counseling Experience

Your therapy session is a 50-minute hour. Counseling is a unique and highly individualized experience. It is an opportunity to learn about yourself, your relationships, and the world around you. Most people seeking counseling are hoping for improvement in at least one area of their life and this is possible through dedication and consistent counseling sessions. Although you may want immediate relief, it is common for symptoms to get worse before they get better. Remember that it may have taken time for your struggles to develop, and it may also take time for you to begin to feel better.

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Counseling involves change, which may feel threatening, not only to you, but also to those people close to you. The prospect of giving up old habits, no matter how destructive or painful, can often make you feel very vulnerable. At the same time, counseling can aid you in discovering tools and techniques which can be utilized to improve the quality of your life and relationships. As the person involved in this process, you have the right to ask your therapist questions about his/her professional experience, background, and theoretical orientation.

Darla Gale Counseling, Marriage and Family Therapist, Inc. receives and responds to complaints regarding the practice of psychotherapy. To file a complaint, contact DarlaGaleCounseling@gmail.com

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Please ask for any clarification needed for the above

Acknowledgement

By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this Agreement. You have discussed such terms and conditions with us and have had any questions answered to your satisfaction. You agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with us. Moreover, you, as the Client or Representative, agree to hold the therapist and Darla Gale Counseling, Marriage and Family Therapist, Inc. free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever that may result from such treatment.

_____

Client Signature Date

_____

Client Signature Date

_____

Kimberly Goehring, MA, Registered AMFT #139877 Date
Supervised by Darla Gale, MA, LMFT #92413

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HIPAA Notice of Privacy Practices for Protected Health Information (PHI)

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

I. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

II. We have a legal duty to safeguard your protected health information (PHI). We are legally required to protect the privacy of your PHI, which includes information that can be used to identify you that we've created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this Notice about our privacy practices, and such Notice must explain how, when, and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply, or analyze such information within our practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside our practice. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And we are legally required to follow the privacy practices described in this Notice.

III. How we may use and disclose your PHI.

We will use and disclose your PHI for many different reasons. For some of these uses or disclosures, we will need your prior written authorization; for others however, we do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Use and disclosures relating to treatment, payment, or health care operations do not require your prior written consent. We can use and disclose your PHI without your consent for the following reasons:

1. For treatment. We can use your PHI within our practice to provide you with mental health treatment, including discussing or sharing your PHI with our trainees and associates. We can also disclose your PHI to physicians, psychiatrists, psychologists and other licensed health care providers who provide you with health care services or are involved in your case. For example, if a psychiatrist is treating you, we can disclose your PHI to your psychiatrist to coordinate your care.

2. To obtain payment for treatment. We can use and disclose your PHI to bill and collect payment for treatment and services provided by us to you. For example, we might send your PHI to your insurance company or health plan to get paid for health care services that we have provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

3. For health care operations. We can use and disclose your PHI to operate our practice. For example, we might use your PHI to evaluate the quality of health care services you received or to evaluate the performance of the health care professionals who provided such services to you. We may also provide your PHI to our accountant, attorney, consultants or others to further our health care operations.

4. Patient incapacitation or emergency. We may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as we try to get your consent after treatment is rendered, or if we try to get your consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) and we think you would consent to such treatment if you were able to do so.

B. Certain other uses and disclosures also do not require your consent or authorization. We can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state or local laws require disclosure. For example, we may have to make a disclosure to applicable governmental officials when a law requires us to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or claim for workers' compensation benefits, we may have to use or disclose your PHI in response to a court or administrative order. We may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, we may have to use or disclose your PHI in a response to a search warrant.
4. When public health activities require disclosure. For example, we may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.
5. When health oversight activities require disclosure. For example, we may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
6. To avert a serious threat to health or safety. For example, we may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.
7. To remind you about appointments and to inform you of health-related benefits or services. For example, we may have to use or disclose your PHI to remind you about your appointments, or give you information about treatment alternatives, other health care services or other health care benefits that we offer that may be of interest to you.

C. Certain uses and disclosures require you to have the opportunity to object.

1. Disclosures to family, friends or others. We may provide your PHI to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other uses and disclosures require your prior written authorization.

1. In any other situation not described in sections III A, B, and C above, we will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action in reliance on such authorization) of your PHI by us.

IV. What rights you have regarding your PHI

You have the following rights with respect to your PHI:

A. The right to request restrictions on Our Uses and Disclosures. You have the right to request restrictions or limitations on our use or disclosures of your PHI to carry out our treatment, payment, or health care operations. You also have the right to request that we restrict or limit disclosures of your PHI to family members or friends or others involved in your case or who are financially responsible for your care. Please submit such requests to us in writing. We will consider your requests, but we are not legally required to accept them. If we do accept your requests, we will put them in writing and we will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that we are legally required to make.

B. The right to choose how I send PHI to you. You have the right to request that we send confidential information to you at an alternate address (for example, sending information to your work address instead of your home address) or by alternate means (e-mail instead of regular mail). We must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide us with information as to how payment for such alternate communications will be handled. We may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The right to inspect and receive a copy of your PHI. In most cases, you have the right to inspect and receive a copy of such information in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to your request within 30 days of receiving your written request. In certain situations, we may deny your request. If we do, we will tell you in writing our reasons for the denial and explain your right to have it reviewed. If you request copies of your PHI, we will charge you not more than $.25 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

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D. The right to receive a list of the disclosures we have made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which we have disclosed your PHI. The list will not include disclosures made for our treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel. We will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list we give you will include disclosures made in the last six years unless you request a shorter
time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you made more than one request in the same year, we may charge you a reasonable, cost-based fee for each additional request.

E. The right to amend your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request to correct or update your PHI. We may deny your request in writing if the PHI is (i) correct and complete ,
(ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that our denial be attached to all future disclosures of your PHI. If we approve of your request, we will make the changes to the PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The right to receive a paper copy of this notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via email.

V. How to complain about our privacy practices

If you think that we may have violated your privacy rights or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. Person to contact for information about this notice or to complain about my privacy practices

I, Marriage and Family Therapist, Inc. if you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Darla Gale Counseling, Marriage and Family Therapist, Inc. Attention Darla Gale, LMFT#92413 6135 King Road, Suite D, Loomis, CA 95650

VII. Effective date of this notice

This notice went into effect on December 23, 2021

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that we have given you. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice from us by contacting us at (916) 676-7405. If you have any questions about our Notice of Privacy Practices, please contact us at: Darla Gale Counseling, Marriage and Family Therapist, Inc. 6135 King Road, Suite D, Loomis, CA 95650 916-676-7405

I acknowledge receipt of the Notice of Privacy Practices of Darla Gale Counseling, Marriage and Family Therapist, Inc.

Signature:_____ Date:_____
(patient/parent/conservator/guardian)

Signature:_____ Date:_____
(patient/parent/conservator/guardian)

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Sliding Fee Schedule

Darla Gale Counseling, Marriage and Family Therapist, Inc. regular hourly session fee is $150. However, if you are unable to afford the regular session fee, we offer a Sliding Fee Scale determined by your gross monthly income and ability to pay. Monthly income includes all forms of household income (such as pension, disability, unemployment, stipends, commission, salary, alimony, child support, etc.). Dependent session fees are determined by the monthly income of the legal guardians of the child.

Payment of fees will be due at the beginning of each session by cash, check, or credit card. As a reminder, cancellations must be made 24 hours in advance. If an appointment is cancelled or missed without 24 hours of notice, you will be charged for the missed session.

Monthly Income	**Session Fee**
$0 - $2,000	$120
$2,001 - $3,000	$130
$3,001 – 5,000	$140
$5,001-Above	$150
Court Ordered Therapy, Couples and/or Families	$150
Brain Spotting and EMDR	$150

Good Faith Estimate Notice to Clients and Prospective Clients

Under the law, healthcare providers need to give clients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services. You can ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service, or at any time during treatment. If you receive a bill that is at least $400 more than your good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, or how to dispute a bill, see your Estimate, or visit https://www.cms.gov/no surprises

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Symptom & Problem List

Please check all that you have experienced in the last 90 days

- ☐ No energy
- ☐ Cannot Enjoy Life
- ☐ Memory Problems
- ☐ Anxiety
- ☐ Fatigue
- ☐ Anger Outbursts
- ☐ Shortness of Breath
- ☐ Sweating
- ☐ Hot flashes
- ☐ Reliving Past Events
- ☐ No Loving Feelings
- ☐ Fears
- ☐ Chest Pains
- ☐ Decisions Difficult
- ☐ Racing Thoughts
- ☐ Clammy Hands
- ☐ Hard to Make Friends
- ☐ Flashbacks
- ☐ Overeating
- ☐ Suicidal Thoughts
- ☐ Taking Pain Killers Often
- ☐ Mood Swings
- ☐ Unusual Experiences
- ☐ Physical Numbness
- ☐ Panic Attacks
- ☐ Losing Track of Time
- ☐ Impaired Vision
- ☐ Back Pain
- ☐ High Risk Activities
- ☐ Insomnia
- ☐ Disturbing Memories
- ☐ Low Self-Esteem
- ☐ Poor Appetite
- ☐ Headaches
- ☐ Nightmares
- ☐ Heart Palpitations
- ☐ Depressed
- ☐ Guilt Feelings
- ☐ Poor Concentration
- ☐ Blackouts/Fainting
- ☐ Unwanted Thoughts
- ☐ Out of Control Behavior
- ☐ Overly Confident
- ☐ Distractible
- ☐ Sexual Indiscretion
- ☐ Socially Withdraw
- ☐ Eating Disorder
- ☐ Alcohol Use
- ☐ Seeing things
- ☐ Excess Energy
- ☐ Unsure of Reality
- ☐ Wishing to Die
- ☐ Confusion
- ☐ Weight Change
- ☐ Impaired Hearing
- ☐ Muscle Spasms
- ☐ Tremors
- ☐ Unsure of Identity
- ☐ Seizures
- ☐ Sporadic Dieting
- ☐ Sexual Difficulty
- ☐ Hypertension
- ☐ Racing Heart
- ☐ Stomach problems
- ☐ Sleeping too much
- ☐ Always on Guard
- ☐ Apathetic
- ☐ Numbing Out
- ☐ Distrustful
- ☐ Buying Sprees
- ☐ Drug use
- ☐ Family Arguments
- ☐ Often Physically ill
- ☐ Hearing Voices
- ☐ Vomiting
- ☐ Slowed Thinking
- ☐ Physical Violence
- ☐ Easily Startled
- ☐ Work Problems
- ☐ Hopeless Feelings
- ☐ Dizziness
- ☐ Hallucinations

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Credit Card Agreement

Please note: New clients are required to keep a valid credit card number on file. Please complete the following information and provide your credit card to the counselor at your initial session.

CC Type: MC Visa Amex Other_____

Name as shown on card_____

CC Number_____

CC Expiration Date_____

3-digit security code on back of the card_____

Billing Zip Code associated with the card_____

This card may be charged for:

__X__Regular session fees (at your request, as a convenience to you)

__X__Fees for cancellation without 24_hours' notice (according to a counselor's policy)

__X__Delinquent session fees (fees more than 30 days overdue)

"I _____(print name) have read and understand the terms of providing my credit card to Darla Gale Counseling, Marriage and Family Therapist, Inc. I understand that my credit card may be charged for the reasons indicated above. Any questions I have about this practice have been answered.

_____

Signature Date