



1. Please describe your reason(s) for seeking counseling at this time. If there is a particular event which triggered your decision to seek counseling now, please describe:

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2. What result(s) do you expect from counseling?

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3. Have you ever participated in mental health services before? If so, please list dates, provider name, and the concerns for which services were sought:

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4. Please list any medications you're currently taking:

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5. Please share how you were referred to my practice:

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### **Counseling Philosophy**

I am a Licensed Professional Counselor in the state of Pennsylvania and a National Certified Counselor. I believe in providing a Client Directed Outcome Informed counseling approach. This means that I work very hard to form partnerships and focus on maintaining ongoing collaboration. Above all, I am dedicated to you achieving your goals. Your ideas and opinions are critically important. I will work with you to learn what your goals for services are, and I will ask for your ideas about the best ways to reach those goals. If you're not sure about how to do that, I will try to help you generate some ideas. In partnership, we will decide the best way to proceed.

### **Play Therapy**

Child Centered Play Therapy can be a beautiful and effective way to help children and works for children as counseling or psychotherapy does for adults. Child Centered Play Therapy helps children work through emotional, psychosocial and behavioral difficulties and helps address family problems. In Child Centered Play Therapy, a relationship develops between the child and the therapist. The therapist enters the child's world, following the child's lead, developing a safe place and a relationship of trust. Play Therapy sessions are usually held in a playroom that has a range of carefully selected toys and materials. In special circumstances, Play Therapy sessions can also be offered in other settings such as home and in hospital. In the playroom, the child can express feelings, thoughts, experiences and behaviors through play. Toys are used like words and become the child's natural language. In Child Centered Play Therapy the child selects the toys and activities to play with. The Play Therapist may join in the play on the child's direction or invitation. Limits are set as and when needed. This is done in a way that helps children make choices and develop self responsibility. Play Therapy is designed to help children grow up as happy and well adjusted as possible.

### **Financial Terms**

Payment is required at the time of service. If you plan on utilizing insurance, upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and I will be paid directly by the carrier. By signing below, you authorize this provider to submit claims to your insurance carrier. You will be responsible for any applicable deductibles and co-payments. Co-payments must be paid, with either check or cash, at the time of services rendered. If you are not eligible at the time services are rendered, you are responsible for full payment. Our fees are:

**\$100.00 for Initial Session – 1 hour**  
**\$90.00 for Subsequent Sessions – 45 minutes**

### **Cancelled/Missed Appointments**

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than twenty-four hours notice, you will be billed directly according to the scheduled fee or according to the rules of your health plan. Your health plan does not cover payment for missed appointments; therefore, you are responsible for payment in full.

### **Emergency Procedures**

If you need to contact me, leave a message according to the instructions on the phone service and your call will be returned. If an emergency situation arises, follow the emergency procedures and/or state that your call is an emergency. Please do this for true emergencies only. There may be a charge for lengthy telephone consultations.

**Release of Information**

I authorize the release of information regarding my care to my health plan for the payment of claims, certifications, case management decisions, and other purposes related to the administration of benefits for my health plan. Please note that I will not appear or testify in court related cases. This includes custody and worker's compensation cases.

**Consent for Treatment**

I further authorize and request that my counseling provider carry out mental health examinations, treatment, and/or diagnostic procedures which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of counseling is designed to be helpful, it may at times be difficult and uncomfortable.

*I understand and agree to all of the above information.*

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Client (or Parent/Guardian) Name Date

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Parent/Guardian Name Date