The Center for Christian Counseling and Care, PLLC

1 West 10th Street, Shawnee, OK 74801 - 405-275-2222

Larry Roberts, MS, LMFT

First name _____ Middle initial _____ Last name _____

Date of birth _____ Social security number _____ Male ___ Female ___

Phone: Cell _____ OK to receive text? Y N OK to leave msg? Y N

Address _____ City _____ State_____ Zip _____

Employer name _____ Work phone _____

Emergency Contact _____ Phone _____Relationship _____

Who referred you? _____

Type of payment: ☐ Private Pay ☐ EAP ☐ Employer ☐ Other _____

******If it is someone other than client******

Person responsible for account: Name _____ Phone _____

Social Security # _____ Date of birth _____ Address _____

City _____ State _____ Zip _____

Note: **Payment is expected at the time of service unless arrangements are made with your therapist prior to your appointment**. You are responsible for the total amount of charge whether paid by you or a third party. The Center for Christian Counseling and Care, PLLC will file the claim to your insurance company. All pertinent information must be completed and signed by the authorizing person. If you have any questions about your fees, discuss them with your therapist. Charges not paid will be turned to a collection agency.

I further understand that I will be charged the full fee for any appointment not cancelled 24 hours in advance or for any appointment that I do not keep. My signature below indicates I understand and accept responsibility for services rendered at the time of each appointment.

Signature _____ Date _____

The Center for Christian Counseling and Care, PLLC

1 West 10th Street, Shawnee, OK 74801-6801
Phone: 405-275-2222 Fax: 405-275-7740

The Center for Christian Counseling and Care facilitates mental, emotional, relational, and spiritual health in individuals, couples and families through counseling, education, and related services. This is our ministry. We do not seek to impose doctrine or our own theological views on our clients, but will certainly seek to utilize our clients' own faith understandings if they can be beneficial for treatment.

CONFIDENTIALITY

Confidentiality means that therapists have a responsibility to you to safeguard information obtained during treatment. It is important that you understand that all identifying information about your assessment and treatment is kept confidential. Even within the agency, information about your case is only shared with those other therapists who might be able to enhance the services you receive.

In order to protect your confidentiality, any written, telephone, or personal inquiries about clients will not be acknowledged. You must sign a release of information before any information about you is given outside the agency. In order for us to coordinate our treatment with other mental health or medical professionals, we will ask you to sign a release of information to allow us to discuss or correspond with other professionals who may have been involved in your care.

It is important that you understand that the laws of the State of Oklahoma mandate exceptions to confidentiality in specific cases. In certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, in these situations we are not required to inform you of our actions.

1. A mental health professional is required to report suspected child abuse or neglect and to report suspected abuse of the disabled or elderly.
2. A mental health professional is required to disclose information to law enforcement personnel in order to protect the client or others when there is a high probability of imminent physical injury.
3. A mental health professional may be required by the court to disclose treatment information in proceedings affecting the parent-child relationship.
4. A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
5. There is no confidentiality of mental health information in connection with criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
6. In the treatment of a minor client, a mental health professional may advise a parent or guardian of a minor, with or without the minor's consent, of the treatment needed by or given to the minor.

COURT PROCEEDINGS

It is not the mission of The Center for Christian Counseling and Care to speak on behalf of our clients in current or potential court proceedings. Ethical and legal standards established by mental health professional licensing boards prohibit therapists from testifying as expert witnesses on behalf of their clients, as the nature of the therapist-client relationship inherently biases the therapist toward the client and any testimony can be potentially damaging to the therapeutic relationship. If you feel that you are involved in a case that has the potential to go to court, or you need an independent, objective psychological assessment for court purposes, please let the therapist know so that we can offer you the appropriate referral. In the event that the therapist is subpoenaed to testify in court on behalf of a client, the client will be charged, in advance, a fee of $150 per hour for the therapist's time. We will require a $1,000 retainer fee after being subpoenaed, and will issue a check back to clients for any hours not used in preparing for court, time travel to court, waiting in court to testify, and hours missed counseling other clients while in court.

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THE RISKS OF COUNSELING

To allow you to make an informed decision about your treatment, please understand that you may experience discomfort, such as anger, depression, or frustration during therapy as you remember and therapeutically resolve unpleasant events. Seeking to resolve concerns between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended.

The Center for Christian Counseling and Care is not an emergency service. Our therapists are not able to return your calls immediately or schedule you for immediate treatment. In the event of an emergency, please call 911 or go to the nearest emergency department.
The greatest risk of counseling is that it may not by itself resolve your concerns. We do our best to assess progress on a week-to-week basis. If a situation fails to improve or a situation deteriorates, we will provide referral to another professional for consultation or treatment.

BENEFITS OF COUNSELING

Counseling has proven, in extensive outcome studies, to be successful in treating and helping individuals, couples, and families resolve: feelings of depression, failure, anxiety, or loneliness; unmanageable anger, hostility, or violence; persistent difficulty coping with stresses arising from life crises, such as death, divorce, acute or chronic illness, or unemployment; persistent problems with a child's behavior, school adjustment, or performance; chronic work difficulties or frequent job changes; alcohol or drug abuse; repeated financial difficulties; persistent feelings of dissatisfaction with marriage or family life; sexual concerns; and drastic weight fluctuations or irregular eating patterns.

FEES AND APPOINTMENTS

The Center for Christian Counseling and Care accepts most insurance as well as SoonerCare and an array of Employee Assistance Programs (EAP's). Services may be covered in full or in part by your health insurance or employee benefit plan. You may want to contact your insurance provider to determine eligibility and coverage. Payment is expected at the time services are rendered.
Therapy sessions are by appointment only. If you do not show up for your scheduled therapy appointment, and you have not notified us at least 24 hours in advance, you will be subject to a missed appointment charge equal to a full session fee.

TERMINATION OF THERAPY

You may leave therapy at any time. If you decide to discontinue therapy, please discuss your decision with your therapist.

If a situation fails to improve or a situation deteriorates, we will provide referral to another professional for consultation or treatment. If a problem is outside the boundaries of our competence (legal issues, financial planning, medication questions, etc.), we will refer you to another professional.

Initials and Signature Page

I grant my permission for any therapy, testing, or diagnostic evaluation that the staff of The Center for Christian Counseling and Care may deem necessary in individual, marital or family therapy. I understand the potential for emotional discomfort and relationship changes not originally intended. I understand The Center for Christian Counseling and Care does not guarantee any particular results or outcome from the therapy process.
(Initials) _____

I understand and agree to the confidentiality policies of The Center for Christian Counseling and Care. These include the exceptions to confidentiality mandated by state law. These also include the possibility of sharing information shared in individual sessions, phone conversations, or written messages with those family members or other interested parties to whom I have granted a release of information.
(Initials) _____

If using third party reimbursement (i.e., insurance) to pay for my sessions, I understand and agree that my therapist will provide only that information necessary to the third party to process my claims.
(Initials) _____

I understand the risks of counseling as explained above. I understand that The Center for Christian Counseling and Care is not an emergency facility and in the event of an emergency, I agree to contact 911 or go to the nearest Emergency Department for treatment.
(Initials) _____
I understand that I will be required to pay a $1,000 retainer fee if I am involved in a court case in which my attorney subpoenas my therapist to court for her or his testimony.
(Initials) _____

(To be filled out with the therapist) I agree to pay the fee of _____ per session for therapy services, and that **I can and will be charged for the same fee for a missed appointment not cancelled 24 hours in advance**. (Notice: Insurance carriers will not reimburse for missed sessions; client will be responsible for entire amount – not just copay).
(Initials) _____

I give my consent for treatment for myself or my child,_____, at The Center for Christian Counseling and Care. I understand all of the above sections that I have initialed, and agree to pay for services when received.

_____ _____
Client signature Date

_____ _____
Signed (spouse, child, or other) Date

_____ _____
Signed (child or other) Date

_____ _____
Therapist signature Date

Confidential Information. Not to leave CCCC without consent

CONSENT FOR RECORDING SESSIONS

I (we) authorize Larry Roberts, MS, LMFT to audio/video record sessions for the purpose of providing quality clinical care. Recorded sessions may be used only for the purpose of therapeutic training, consultation and education, and will not be used for any other purpose. All professionals in the field who may view these recordings are bound by confidentiality and I will not use or permit the use of the your full name or other specific identifying information not contained in the recording that might reveal the identity of the client(s).

Recorded sessions are kept confidential and are not considered part of your medical record. Recordings are stored on my password protected laptop computer and are deleted upon request.

Sessions will never be recorded without your awareness and consent. This consent form can be withdrawn at any time by writing void across this form and signing it in my presence.

We consent to the recording of our session(s) to be viewed by a representative of the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT). We understand that this recording will be kept confidential and viewed only by a Certified EFT therapist as part of the ICEEFT Certification procedure. The ICEEFT representative will also take responsibility for destroying the recordings after viewing them.

_____	_____	_____	_____
Client Signature	Date	Other/Family Member	Date
_____	_____	_____	_____
Other/Family Member	Date	Other Family Member	Date
_____	_____	_____	_____
Other	Date	Other	Date
_____	_____		
Therapist Signature	Date		

* Each person present for video recording is required to sign this form.