Client Information **Date:**_____

Name_____ Date of birth_____ Age___

Address_____
(Street) (City) (Zip)

Preferred phone number_____
Is it okay to leave a message at this number? Yes ◯ No ◯

Would you like to receive email communication for information such as appointment notifications and practice updates? Yes ◯ No ◯ Email:_____

Would you like to receive my monthly Insights Anew email newsletter containing information about families, relationships, parenting, mental health, and wellness?
Yes ◯ No ◯ Email:_____

Family Members – *Please provide information about those family members involved in therapy*.

Name	Age

Brief History

Reason for coming to therapy: _____

_____

Have you or your family members been in therapy before? Yes ◯ No ◯

If yes, briefly explain: _____

Have you or your family members been hospitalized for psychiatric reasons? Yes ◯ No ◯

If yes, briefly explain: _____

Referred by_____

Please read and sign this therapy agreement. If you do not understand any part of this agreement please ask any questions prior to the start of therapy.

I hereby grant my permission for Karin Weiri-Kolle, LMFT, to provide psychotherapy services for myself and my minor child(ren). This therapy may include individual, couple or family sessions, as necessary to meet our therapeutic goals.

Confidentiality Agreement:
I understand that anything said in therapy is confidential, *except* for the following limitations:

- Child abuse and/or neglect (Florida statute 39.201),
- Vulnerable adult abuse or neglect (Florida statute 415.1034),
- Threats to harm oneself (Florida statute 413.341),
- Threats regarding harm to another person (Florida statute 413.341),
- A court subpoena, or
- My specific request, in writing, to disclose information regarding my psychotherapy to a third party.

Payment Agreement:
I understand that:

- My fee, payable by cash or check, is due after each session.
- I need to cancel an appointment within *24 hours,* or *I will be charged the full fee.*
- If my check is returned, I will be charged a $30.00 processing fee and my outstanding balance will be due prior to receiving additional services.

Parental Notification:

- I understand that it is the policy that both legal parents are informed when a child attends therapy. If both parents are not attending the sessions with the child, I agree to inform the other parent that the child is being seen for therapy.
- If my child is seen privately for therapy, we will agree in advance the limits of confidentiality for those sessions. My child will be aware of this prior to engaging in therapy.

Emergencies:
I understand that my therapist is not available 24 hours a day and that in a crisis situation, I should call the SMA Behavioral Health Hotline 1-800-539-4228 or 911.

All participants, 18 years of age or older, are required to sign this agreement prior to attending a therapy session. Minor children are invited, but not required, to sign this agreement.

Print Name	Signature	Date