Success Strategies Unlimited, Inc
Jennifer Dunham, LPC, LPC-S, CHT
Client Intake Form

Name:_____

Address:_____

City:_____ Zip:_____

Contact Phone Number:_____ Alternate Number:_____

SS#:_____ DL#:_____

Marital Status:_____ Date of Birth:_____

Employer:_____ Occupation:_____

Reason for Consulting Jennifer Dunham:_____

Referred By:_____

Current Medications (including OTC):_____

_____

Have you been to a therapist in the past: Yes/ No
If so, when and for what reasons:_____

THERAPY AGREEMENT:
By signing this form, I understand and agree to the following:

A session lasts 45 minutes; a half session lasts 25 minutes; a double session lasts 80 minutes. Full payment is expected at each session**. Your session time is reserved for you. There is a charge of $150 for appointments not kept, canceled, or rescheduled within 24 hours *for any reason*.** This fee is **NOT** billable to insurance companies. Phone consultations over 5 minutes are charged at the rate of $3.50 per minute for the full duration of the call. A fee of $35.00 is charged for returned checks.

My Travel Obligations as a National Crisis Counselor
Occasionally I am called out of the office to respond as a Crisis Counselor to provide support during major disasters and crisis situations nationwide. Should I be called out when we have a session, I will contact you and offer to reschedule our session as quickly as possible.

I have read the *Notice of Privacy Practices and Informed Consent* for the office of Success Strategies Unlimited, Inc.

Records preparation, forms, letters and court related services such as: consultation with attorneys, depositions, court appearances and travel time will be charged at an hourly fee of $300.00. It shall be your responsibility to pay for all cost involved and payment may be required prior to the time services are rendered, but, in no case, later than at the time that service is rendered. Note that these services do not fall under the scope of reimbursement by your insurance company.

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to Jennifer Dunham benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents and/or fees for appointments not kept or cancelled/rescheduled within 24 hours of the appointment time. I give Jennifer Dunham the right to seek the services of a bill-collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid to her for services rendered and/or for cancelled, missed appointments or for late rescheduled appointments.

Any outstanding balance may be charged to my credit card. VISA ____ MC ____

Card Number:_____

Three Digit Number on the back of your card:_____

Expiration Date:_____

Name on the Card:_____

_____

Signature of Patient (or Parent if Patient is a Minor) Date

Mental Health Professionals regularly seek consultation with their colleagues to ensure the highest quality of therapy and treatment for the clients and prevent personal biases from hindering the therapeutic process. Despite the extra expense to the therapist for this consultation, it is essential to maintain the highest standards for your care. All legal and ethical confidentiality laws and standards apply during these professional consultations.

I give my permission for Jennifer Dunham to provide mental health services to me. *Hypnotic trance is NOT induced during an initial session and is used thereafter with client consent*.

I understand that after the final session or in the event that I have not attended a therapy session in three months, the client/therapist relationship will be considered closed unless I initiate further contact.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent or Guardian if a Minor Email Address