The Practice of Alexis Honeycutt, LMHC, NCC, QS (FL)

Counseling Agreement

The following is an agreement between Alexis Honeycutt, LLC and:

Name:____DOB:_________________

Address: ____

City:____________________________State:__________ZIP: __________________

Phone:___________________________Cell: ________________________________

Email:______________________________OK to leave messages? _______________

How did you hear about my practice? _______________________________________

Emergency Contact: ____

Relationship:___________________________Phone: __________________________

Appointment Agreements:

1. Counseling sessions are scheduled for **50** minutes. If the session extends beyond 60 minutes, I understand I will be charged appropriately.
2. I am responsible for showing up for counseling at the pre-appointed time. I understand if I am late, I may not be able to have a full session but will be charged for such.
3. I understand that my session fee will be charged the morning of the scheduled appointment and that if the method of payment on file is declined, I will be asked to provide another method of payment before the session can begin.
4. I understand that after 3 cancellations I will not be able to be put back on therapist schedule.
5. **I agree to give a 24-hour notice of cancellation. If I provide less than a 24-hour notice or fail to show up for my appointment, I understand that I will be charged the full session price (50 min. = $175.00 /90 min. = $315.00).**

6. Phone calls with Alexis Honeycutt, LMHC are billed in 15-minute increments 15 min. = $52.50; with a billed minimum of 15 minutes.

7. Administrative preparation of forms and paperwork completed on behalf of the client is billed per minute at the session rate. No administrative work will be billed for unless the client specifically requests such.

Financial Agreements:

1. I have agreed on the following session rate of **$175** per 50 minute session.
2. I understand that monies paid in advance are non-refundable.
3. Payment is required before or at the time services are rendered. If payment is not received before or at the time of service, I understand that no further sessions can be scheduled or honored until payment is made in full.
4. Handwritten receipts will be provided **only** if expressly requested during the time of the session. Receipts will not be provided retroactively. Superbills will not be provided by the practitioner nor her staff.
5. Payment options include HSA/FSA, Credit/Debit Card (MC, Visa, Amex).

Credit Card Information:

In order for counselor to collect cancellation and no-show fees as appropriate, credit card information will be recorded below. I authorize Alexis Honeycutt, LLC to charge this credit card for sessions, phone call fees, cancellation fees (see above) as appropriate. This credit/debit card will also be used for all fees that have not been paid within 30 days. I understand that I may revoke this agreement at any time by providing a request in writing.

Name on Card: ____

Credit Card Number: ____

Exp Date: __________ Billing Zip Code: ____________ Security Code: ______

Signature: ________________________ Date: ______________

Confidentiality:

I understand that I have a right to privacy. In other words, what is said in session with my counselor will not be revealed to others. There are exceptions to this confidentiality by law:

1. I sign a written release of information, therefore, waiving my right to privacy and providing Alexis Honeycutt, LLC with permission to disclose information to the person or institution I specify.
2. In the event that my counselor receives a court order to release information about me. I will be notified that the requested information will be released.
3. My counselor feels that I pose a danger to myself or others. This may include but is not limited to: high risk of suicide, perpetrator of abuse or neglect of a child or elderly person, or homicidal plans.

Discharge: I understand that I will be administratively discharged if more than 60 days have elapsed since my last session.

Liability Release:

I,________________________________, take full responsibility for my choices and behaviors during and as a result of counseling. I release my counselor from any financial, legal, physical, or psychological impact that results from my participation in counseling as well as any claim for failure on my part to produce the results I intended.

I have read, understood, and accept the terms of this contract.

Signature: _____________________________ Date: __________________

While I am Certified in Gottman Method Couples Therapy, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for the provision of those services. The Gottman Institute nor its agents have any responsibility for the services you receive.

Electronic Communication Consent Form

I acknowledge that commonly used e-mail and texting services are not secure.

I have been given the opportunity to discuss electronic communication with Alexis Honeycutt LMHC, and have had all my questions answered.

In consideration of my desire to use electronic communication as supplement to in-person office visits with my provider, I hereby consent to electronic communication via non-secure e-mail and text services.

I understand that I may revoke my consent to communicate electronically at any time by notifying Alexis Honeycutt, LMHC in writing, but if I do, the revocation will not have any effect on actions my healthcare provider has already taken in reliance on my consent.

I agree to release my provider and the practice from any and all liability that may occur due to electronic communication over a non-secure network.

I further agree to be held accountable for the patient responsibilities as outlined.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with Alexis Honeycutt, LMHC.

Signature: ________________________________ Date: ____________________

Personal History Information:

Chief Complaint or issues you are concerned with:

____

____

List any major health problems for which you currently receive treatment:

____

From whom or where do you get your medical care?

Name:____

Address:____

Phone: ____

If you enter treatment with me, may I tell your Medical Doctor so that he/she can be fully informed, and we can coordinate treatment? Yes __ or No __

List all medications you are currently taking:

____

____

____

Have you ever received psychiatric help or counseling of any kind before? Yes__ or No__

What was the result?

____

____

____

Initials: ______

Identification of Symptoms:

Please indicate any of the following problems that you are experiencing currently:

Nervousness __	Isolating __	School Problems __
Shyness __	Sexual Problems __	Suicidal Thoughts __
Separation	Divorce __	Financial Difficulty __
Anxiety __	Drug Use __	Alcohol Use __
Aggression __	Friends __	Anger __
Depression __	Self-Control __	Unhappiness __
Fears __	Sleep Difficulties __	Stress __
Distractibility __	Work __	Relaxation __
Panic/Anxiety Attacks __	Headaches __	Fatigue __
Weight Issues __	Legal Matters __	Memory __
Eating Problems __	Ambition __	Lack of Energy __
Grieving __	Insomnia __	Making Decisions __
Childhood Issues __	Loneliness __	Inferiority Feelings __
Impulsiveness __	Concentration __	Education __
Infidelity __	Career Choices __	Health Problems __
Mood Swings __	Temper __	Nightmares __
Motivation __	Marital Problems __	Children __
Self Esteem __	Appetite __	Being a Parent __
Troubling Thoughts __	Stress Management __	

Initials: ______