White Heron Counseling
Healing and Wellness

ADULT PERSONAL INFORMATION

Name:_____ Date: _____

Home Phone:_____ Cell Phone:_____

Street Address: _____City: _____Zip: _____

Age: _____ DOB: _____ Email: _____

Married _____ Partnered _____ Single _____ Separated _____ Divorced _____ Widowed _____

How long (to all that apply above)_____Referred by:_____

FAMILY DATA

Spouse/partner name: _____ Age: _____M/F: _____ Lives with you? _____

Child name: _____ Age: _____ M/F: _____Lives with you?_____

Child name: _____ Age: _____ M/F: _____Lives with you?_____

Child name: _____ Age: _____ M/F: _____Lives with you?_____

Are you currently in counseling? Yes [ ] No [ ]

If yes, name and address: _____

Prior counseling, name(s) and date(s): _____

Current medications/dosages (include over the counter): _____

_____

_____

Have you had any problems with medications? _____

_____

_____

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TYPE OF HELP DESIRED

[ ] Parenting education [ ] Individual counseling [ ] Group counseling
[ ] Family counseling [ ] Couples counseling [ ] Substance use/abuse treatment
[ ] LENS (Neurofeedback)

Main reason seeking help at this time:_____

_____

_____

How long have you had these problems or symptoms?_____

_____

How often do they occur? _____

Why did you seek help now? _____

_____

What have you tried? _____

_____

Do you have any serious or chronic medical conditions? _____

_____

If yes, dates and details: _____

_____

Have you had any serious accidents/head injuries/seizure activity? _____

If yes, dates and details: _____

_____

Emergency Contact (person/s whom you authorize your therapist to contact in case of emergency):

Name:_____ Phone Number: _____

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DRUG AND ALCOHOL USE

Do you use alcohol? _____ How much per week? _____ Age started drinking? _____

Do you use other drugs? _____ What kind? _____ How much? _____

Do you feel you have a problem with alcohol? _____ Other drugs? _____

Any previous drug/alcohol treatment (inpatient/outpatient)? _____

Has your drinking/drug use caused problems with family or relationships? _____

Has your drinking/drug use caused problems with your job? _____

Is it difficult for you to stop or control the amount you take? _____

Have you been arrested for driving under the influence or other drug related offense? _____

If yes, dates: _____

How many cups of caffeinated beverages do you drink per day (coffee, tea, soda, chocolate)? _____

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FINANCIAL AGREEMENT

The responsible party is the person who is ultimately responsible for payment for psychotherapy services. By signing this agreement, you are indicating that you are the responsible party and that you agree with the following:

- You are responsible for payment for all services rendered either by a debit card, credit card, check or cash. All checks and credit cards will be paid to Eryn Barrett, MFT.
- Payment for services is expected at the time of your visit.
- Appointments must be canceled at least 48 hours in advance to avoid incurring a charge. The 48 hours are within business hours and do not include weekends or holidays.
- The fee for a late cancellation or failed appointment is equal to the charge for a full session.
- There will be a $25 service fee on all returned checks.
- You are responsible for any charges incurred if legal or collection services are required or delinquent accounts.
- Services such as letters written on behalf of clients, written reports or assessments, appearance at meetings with schools or social workers are subject to a fee based on the time involved.
- I am what is referred to as an "Out of Network Provider." I do not bill your insurance company and payment is due at each session. I will provide a "Super-bill" if you are eligible for reimbursement from your insurance company. Services may be covered in full or in part by your health insurance company or employee benefit plan

_____ Date _____
Responsible Party Signature

_____ Date_____
Eryn Barrett, MFT #87926

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CREDIT CARD AGREEMENT

Please note: new clients are required to keep a valid credit card number on file. Please complete following and provide your credit card information to me at your initial session.

Credit card type: MC Visa Amex Other _____
Name as shown on card _____
Credit card number _____
3-digit security code on back of the card _____
Billing zip-code associated with the card _____
Expiration date _____

This card may be charged for:

_____ Regular session fees (at your request, as a convenience to you)
_____ Fees for cancellation without 48 hours notices (according to policy)
_____ Delinquent session fees (fees more than 30 days overdue)

Agreement:
"I, _____ (print name), have read and understand the terms of providing my credit card information to Eryn Barrett, MFT. I understand that my credit card may be charged for the reasons indicated above. Any questions I have about this practice have been answered." I am the responsible party for psychotherapy services or acknowledge and consent to this financial agreement.

_____ Date _____
Responsible Party Signature

_____ Date_____
Eryn Barrett, MFT #87926

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CONSENT FOR TREATMENT

Therapy involves both benefits and risks. Risks include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy often requires recalling experiences, some of which may be unpleasant. Therapy may involve making changes that can feel uncomfortable to you and those close to you. Should you notice any negative effects, please tell me immediately. I will make every effort to remedy the situation or provide you with names of other therapists should you prefer a referral. Psychotherapy has been shown to have benefits for those who undertake it. It often leads to reduction of feelings of distress, and to better relationships and resolution of specific problems. The objective is to find more peace, joy, and healthier relationships.

APPOINTMENTS

The length of a usual appointment is 50 minutes, except for the initial session and sessions including Brainspotting or LENS, which may take up to an 1.5 hrs. Appointments are usually scheduled weekly and on a regular basis until you have accomplished the majority of your goals and other arrangements are made.

CONFIDENTIALITY

As part of the counseling process, I am bound by ethical responsibilities to keep confidential the information shared during the sessions and I will not release any information without your written permission. There are important exceptions to the confidentiality of the counseling relationship. I am required by law to reveal certain information under the following circumstances:

a) Disclosure of serious intent to do harm to self or others
b) Disclosure of child abuse or my suspicion of child abuse, elder abuse, or dependent adult abuse
c) If a court of law orders the release of specific information

INSURANCE

I am what is referred to as an "Out of Network Provider." I do not bill your insurance company and payment is due at each session. However, I will provide a "Super-bill" if you are eligible for reimbursement from your insurance company. Services may be covered in full or in part by your health insurance company or employee benefit plan.

If you have any questions about these policies or about psychotherapy, please ask before signing. Your signature indicates that you have read this policy and agree to enter therapy under these conditions. Further, it indicates your understanding that I may terminate therapy if you do not comply with the policies or if I feel you are not benefiting from treatment.

_____ Date _____

Client/Parent Signature