WVCC
13260 N 94th Dr, Ste 106
Teri Cole, LPC
Toni Durda, LAC
Peoria, AZ 85381

CLIENT APPLICATION

Client Name _____ **Date of Birth** _____

Address _____ **City** _____ **State** _____ **Zip** _____

If client is a minor, both parent's or guardian's name and date of birth

_____

Contact Phone Number

_____

Name of Spouse _____ **Date of Birth** _____ **Marriage Date** _____

Names and date of birth of children living at home:

_____

_____

_____

_____

Emergency Contact and phone number:

_____

Medications and health conditions:

_____

Your goals for counseling:

_____

_____

_____

Describe your strengths:

_____

_____

On a scale of 1-5 (1=poor and 5=excellent) how would you rate your support from friends, family or co-workers?

Family	**1**	**2**	**3**	**4**	**5**
Friends	**1**	**2**	**3**	**4**	**5**
Co-workers	**1**	**2**	**3**	**4**	**5**

Please initial the following items to acknowledge your understanding or consent.

CLIENT COMMUNICATIONS AND APPOINTMENT REMINDERS

_____ Contact and messages

I read the WVCC policy about the potential risks of using electronic media. I understand and agree that WVCC, its counselors or office staff may use or disclose my health information to provide appointment reminders (voice mail messages, phone, e-mail, text, postcards, or letters) or information about treatment alternatives, or health-related benefits and services that may be of interest to me.

_____ Appointment reminders

Prior to each appointment, we will attempt to contact you with an appointment reminder. Please enter your contact info below. Your initials above authorizes us to contact you at these phone numbers / email address for appointment reminders.

Personal Email: _____ Text Message/Phone: _____ Reminder Call Phone:_____

RECEIPTS AND BILLING

_____ Statements and receipts

We can send statements and receipts to you by email upon your request. Receipts may also be provided for you to submit to your insurance. Please initial if you want to authorize receipts to be emailed to your email address provided above.

TREATMENT MODALITIES

I have read and understand the risks and limitations of distance treatment using electronic media (skype, videoconferencing, email, text). I understand that if I choose to communicate confidential information with WVCC via these mediums, WVCC assumes I have made an informed decision and will view it as my agreement to take the associated risks.

_____ I acknowledge I accept the risks associated with treatment via electronic media.

SOCIAL MEDIA

Therapists do not communicate with, or contact clients through social media platforms (Twitter, Linkedin, and Facebook). If we discover we have established an online relationship with you, we will cancel that relationship. Social media contact can create security risks for you. If you have an online presence with your therapist please discuss it in session. We do not respond to social media contact.

_____ I acknowledge I have read and understand WVCC's Social Media policy

MEDICAL RECORDS

_____ I want to be notified by email before my medical records are destroyed. Please email to:_____

FINANCIAL AGREEMENT AND CREDIT CARD AUTHORIZATION

I read the WVCC Fee schedule and non-payment policies in the description of services and understand I am responsible for payment in full at each session via personal check,cash, or debit/credit card. I acknowledge my payment responsibilities and consequences for non-payment of services and have made appropriate arrangements for payment. I acknowledge appointments must be changed or canceled a minimum of 24 hours in advance or I will be charged $40 for late cancellations for appointments before 5 PM and $80 for 5 PM and later.

_____ I read and understand WVCC policies regarding payments and fees

Fill out the information below for automatic billing. We will bill your credit card following each session. You may cancel this automatic billing at any time by contacting us in writing.

Type of Credit Card: □ VISA □ MC

Name on Card: _____

Credit Card #: _____

Expiration Date: _____ / _____ CVV#: _____

Street Address of Card Holder: _____

City, State, Zip Code: _____, _____, _____

Phone Number of Card Holder: _____

I authorize West Valley Counseling Center PLLC and North Valley Medical Billing to charge my credit card for services provided by my therapist. I authorize this information to be kept on file for future use. A receipt for payment will be emailed to me at the email address above.

Client Name: _____ Amount: $ _____

Signature of Card Holder: _____ Date: _____

INFORMED CONSENT

_____ Clients of Toni R. Durda
Toni is a Licensed Associate Counselor and receives supervision from Teri Cole, LPC, and WVCC Clinical Director (602-842-4625). During supervision, your therapeutic treatment needs may be discussed with Teri Cole. If at any time you become uncomfortable with this situation, you are free to terminate counseling and be referred to another counselor. Your client record is the property of WVCC, PLLC .

You acknowledge the following:

- You are entering into an agreement with WVCC, PLLC for psychotherapy services voluntarily, and you are free to discontinue services at any time at your discretion.
- You understand that WVCC may discontinue services at any time if the continuation of services becomes clinically, legally, ethically, or in any way inappropriate. If that occurs, you understand that WVCC will make a good faith effort to help you obtain other appropriate services.
- You have read and understand the client rights and responsibilities.
- You have read and understand the potential risks and benefits of psychotherapy services.
- You understand that the services provided for treatment are not guaranteed to be effective.
- You understand that WVCC and its associates are required by law to report suspected or known child or elder abuse, potential risks to self or others, suspicion of legal or illegal activities that put others at risk, any sexual relationships between a client and another mental health professional, and any other legally reportable incidents which require notification of authorities.
- You have read and understand the limits of client confidentiality.
- You have read and understand WVCC's Description of Services.
- You understand that WVCC and its associates do not provide medication management.
- You understand that WVCC does not provide 24-hour response crisis management services.
- You understand that WVCC does not provide suicide services.

ACKNOWLEDGEMENT: By signing this form, you are acknowledging that you have read the HIPAA and Description Services document, and accept it as outlining the conditions upon which counseling is provided. Your signature further attests that you had opportunity to make a copy of this information for your personal records. Everyone receiving counseling services over the age of 18 needs to sign this document, and typically both parents of a minor (always at least one) should sign as determined by the therapist.

_____ I have read the Informed Consent document, I understand and agree to comply

_____ I hereby affirm that I received and read the HIPAA Privacy notice and WVCC Policies and Procedures form and understand the information.

Acknowledgement
If you are 18 years of age or older, WVCC assumes you are seeking counseling of your own free will and choice, and for reasons that we are unaware of prior to our first meeting. If you are under 18 years of age, you and your parent or guardian are seeking this counseling jointly on your behalf.

By signing this form, you acknowledge you have read all three pages that comprise this material, and accept it as outlining the conditions upon which counseling is provided. Your signature further attests that you had opportunity to make a copy of this information for your personal records. Everyone receiving counseling services 18 years of age or over needs to sign this document, and typically both parents of a minor (always at least one) should sign as determined by the therapist.

_____ _____
Minor's signature if they wish to affirm their participation Date
(not legally recognized as consent for treatment)

_____ _____
Client Signature or Guardian of Minor Child's signature Date

_____ _____
Client Signature Date

_____ _____
Witness Date