**Square One Counseling, LLC**

**Julia Schopp MA, LPC        License # 2014031731**

***Please provide the following information and answer the questions below. Please note:***

***information you provide here is protected as confidential information.***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (First) (Middle Initial)

Birth Date: \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Gender: □ Male □ Female

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated  □ Divorced □ Widowed

Please list any children/age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street and Number)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (City) (State) (Zip)

Home Phone: (      )       May I leave a message?   □Yes □No

Cell/Other Phone: (   )  May I leave a message?   □Yes □No

 May I text message?        □Yes □No

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  May I email you?      □Yes □No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you previously received any type of mental health services (psychotherapy, psychiatric

services, etc.)?  □ Yes □ No

Previous therapist/practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any prescription medication?  □ Yes   □ No

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been prescribed psychiatric medication?  □ Yes    □ No

Please list and provide dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. How many times per week do you generally exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What types of exercise to you participate in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Please list any difficulties you experience with your appetite or eating patterns.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Are you currently experiencing overwhelming sadness, grief or depression?   □ No □ Yes

If yes, for approximately how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Are you currently experiencing anxiety, panic attacks or have any phobias?  □ No □ Yes

If yes, when did you begin experiencing this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Are you currently experiencing any chronic pain?  □ No □ Yes

If yes, please describe? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly

□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? \_\_\_\_\_\_

On a scale of 1-10, how would you rate your relationship? \_\_\_\_\_\_\_\_\_\_

11. What significant stressful events have you experienced recently or in the past:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY MENTAL HEALTH HISTORY:

**If yes, fill in "self" or list the relationship to family member**

Currently Suicidal     yes/no\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol/Substance Abuse     yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self-Harm    yes/no\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety     yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression     yes/no\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Domestic Violence     yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating Disorders     yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obesity     yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obsessive Compulsive Behavior     yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Schizophrenia     yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide Attempts     yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDITIONAL INFORMATION: Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you enjoy your work? Is there anything stressful about your current work?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What do you consider to be some of your strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. What do you consider to be some of your weakness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. What would you like to accomplish out of your time in therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Square One Counseling, LLC**

**Julia Schopp MA, LPC        License # 2014031731**

**Client Information and Consent Form**

**Session Start/End Time** Appointments last either 45 or 90 minutes unless we have made other arrangements. If you arrive late, only the remainder of your session will be available. If I am running late with a prior appointment for some reason, you will still receive your full session time. Thank you for being mindful and respectful of this policy. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Risks and Benefits** Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Counseling** I provide counseling services designed to address many of the issues my clients are dealing with. Your first visit will be an assessment session in which we will determine your concerns, and if we both agree that I can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your therapist and/or psychiatrist, services to you may be terminated. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Fees and Payment** My fee is $120 per 45-minute session/ $240 per 90-minute session. Payments are to be made payable to Square One Counseling, LLC. Payment of fees is expected at the time of each appointment, in the form of cash or personal check. In the event, the client or financially responsible party does not pay for any service when due, client or financially responsible party agrees to pay all cost of collection. There is a convenience fee associated with the use of debit and credit card payments. If checks return for non-payment, you will be responsible for the original fee plus a $50 fee. If there are questions or concerns about the therapy fee, please discuss this matter with me. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Debit/Credit Cards** A convenience fee will be charged as follows.   
**$0-$50** $1.25  **$50.01-$75**$1.75 **$75.01-$100** $2.15 ​**$100.01+**3%​

**Cash and checks are accepted without any associated fees.** \_\_\_\_\_\_\_\_\_\_ **INITIAL**

A credit card will be kept on file for all clientsAll information will be kept confidential in a locked private office with other client files or in a HIPAA-compliant encrypted computer file. All clients must agree to maintain a credit card on file for payment of all missed appointment fees and any balances past due. If your account has not been paid and arrangements for payment have not been agreed upon, the outstanding balance will be charged to the credit card you keep on file with me. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Litigation Limitation** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, workmen’s compensation, injuries, lawsuits, etc…) neither you (client’s) nor your attorney’s nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon. If you do become involved in litigation requiring your therapist’s participation, you will be expected to pay $250.00 per hour for professional time including travel time even if your therapist is compelled to testify by another party. There is also a $100 fee for completing forms that are requested by you or other agencies (i.e. Social Security Administration, short-term disability companies, etc.) This fee/s need to be paid prior to providing such services. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Coverage** In the event that insurance coverage lapses or changes clients are responsible for paying my full fee until their coverage resumes. Please notify me if any changes occur with your insurance coverage to avoid paying full fee for sessions. **\_\_\_\_\_\_\_\_\_\_** **INITIAL**

**Insurance Reimbursement** You are responsible for all out-of-pocket costs at the time of service. **It is your responsibility to contact your insurance company to determine the extent of your coverage and the copay/coinsurance amount.** It is also your responsibility to provide me with any updated insurance information as soon as it has changed. Insurance verification is not a guarantee of payment and insurance companies deny coverage for many reasons. **If a claim is denied, you are responsible for all charges.** I reserve the right to charge any outstanding balance on the client’s credit card on file if balances are not paid in full. If I am not in the network of your insurance company, you will be responsible for paying my fee at the time of services rendered. You can then file a claim for reimbursement from your insurance company. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Cancellation Policy** My clients have always been very respectful of their appointment time, other clients’ appointment times, and my time, but if you must cancel the appointment for any reason, you are required to notify me **at least 48 hours in advance** so that therapy time may be given to another client. It is the client’s responsibility to remember and manage their sessions and cancellation. Please give as much notice as possible for cancelled or rescheduled appointments. Since there is often a waiting list, I can fill cancellations with other clients in need of help. If you miss the appointment or cancel with **less than 48 hours notice**, you will be charged $75, as I am not able to absorb the lost income and it isn’t fair to the clients who want to get in but cannot. Please note INSURANCE COMPANIES DO NOT PAY FOR MISSED SESSIONS. As a result, these charges are the entire responsibility of the client. I will charge missed appointment on the date of the missed session to your credit card on file. You may cancel an appointment without charge, 48 hours in advance by calling 314-808-2346 and leaving a voice mail message or sending an email to [jschopp@socounseling.com](mailto:jschopp@socounseling.com). \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Session Reminders** As a courtesy, I offer appointment reminders that generally arrive 48 hours before the appointment. However, it is up to each client to schedule their appointments on their own calendar and to keep track of session dates whether they receive a reminder or not. If for any reason, you do not receive it, you are still responsible for keeping the appointment and paying the missed appointment fee of $75.You may reach out to the therapist at any time to verify an appointment time. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Wait List/Individual Therap****y Attendance** Individual therapy time slots may be saved for clients and I am dedicated to my clients’ well-being and healing. It is understandable that on rare occasions you may need to cancel your appointment due to a life emergency or illness. My current schedule does not accommodate frequent cancellations**. If there are more than 3 cancellations during a 6 month period, even within the 48-hour cancellation policy, you may be placed on the waiting list and the session time will be opened up to another client in need**. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Telephone and Emergencies** I can be reached at **(314) 808-2346**. If a call involves therapy discussions via telephone, the client will be charged. A discussion of 30 minutes or more will be billed for a full session of $120. A call lasting 15-29 minutes will be billed for a half session at $60 and a call lasting 6 to 14 minutes will be billed $30. A telephone call to schedule, cancel, or change an appointment will not be charged. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

My clients are assumed to be self-responsible and autonomous and not in need of day-to-day supervision. Therefore, I cannot assume responsibility for day-to-day functioning as can an institution (hospital, mental health agency). For me to provide the best care for my clients, if you believe you are in a life-threatening emergency, please call 911 or have someone take you to the nearest emergency room for help. You may also choose to call Life Crisis (314) 647-4357 or BHR at (314) 469-4908. \_\_\_\_\_\_\_\_\_ **INITIAL**

**Contacting Me** I can be reached at **314-808-2346**. I am often not immediately available by phone but you may leave a voicemail message. I will return your call as soon as possible. I do not answer my phone while I am in session. I will make every effort to return your phone call within 24 hours of your call except holidays and weekends. If it is an emergency or there is a risk to yourself or others and you are unable to reach me, call 911 or go to the nearest emergency room. You may also contact Life Crisis Services at 314-647-4357. If I will be unavailable for an extended period, my voicemail message will provide instructions regarding how to contact the therapist covering for me. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Confidentiality/Duty to Warn** In general, the privacy of our communication is protected by law and I can only release information about our work with your written permission. There are a few exceptions to confidentiality. I am a mandated reporter of child, disabled person, and elder abuse. If I believe that someone is at risk of hurting themselves or someone else, I may have to take protective actions which may include contacting the following person(s) in addition to any medical or law enforcement personnel deemed appropriate. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

Name Telephone Number

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Minors** A parent or legal guardian must accompany minors to the first session even if the parent or guardian remains in the waiting area. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Life Threatening Emergency** If you are experiencing a life-threatening emergency, you may not be able to reach me right away. Please call 911 or Life Crisis Services at 314-647-4357\_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Electronic Message Policy** It is understood that any written communication via the internet, including e-mail, or via texting may be susceptible to unauthorized interception. If you do not wish any communication via e-mail, text, or other means, please notify me in writing. \_\_\_\_\_\_\_\_\_\_ **INITIAL**

\_\_\_\_\_ I do NOT want to communicate by any form of electronic messaging.

\_\_\_\_\_ I give you permission to communicate with me by electronic messaging. I understand this form of communication may be susceptible to unauthorized interception.

**Consent to Treat** By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in the Information and Client Consent form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

I understand that I am responsible for all charges regardless of insurance coverage. I give permission for Julia Schopp, MA LPC, to release any information to insurance companies and medical billing services for the purposes of determining benefits, obtaining payment for services, and obtaining authorizations. The permission remains in effect unless specifically revoked by me.

My signature below indicates that I have read and understood the information in this document and agree to the terms during our professional relationship including the 48-hour cancellation policy and associated fees.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client (if age 13 or above) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent or legal guardian of minor client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**\_\_\_\_\_\_ I am not using insurance**

**\_\_\_\_\_\_ I am using insurance**

**My Coinsurance is \_$\_\_\_\_\_\_\_\_\_\_\_\_**

**My Copay is \_$\_\_\_\_­\_\_\_\_\_\_\_\_\_**

**I will CALL and verify the above information prior to the first appointment. I will provide my insurance card and ID upon arrival to my first session. I will update therapist immediately with any insurance changes.** \_\_\_\_\_\_\_\_\_\_ **INITIAL**

**Square One Counseling, LLC/Julia Schopp, M.A., LPC**

**Credit Card Authorization** Since the scheduling of an appointment involves the reservation of time specifically for you, if you must cancel the appointment for any reason, you are required to notify me of the cancelation **at least 48 hours in advance** so that the therapy time may be given to another client. My clients have always been very respectful and it is rare that clients cancel, but due to my current schedule, and in order to support other clients who are on the waiting list who will need enough time to schedule off from work or set up childcare, if you must cancel the appointment for any reason, you are required to notify me **at least 48 hours in advance** so that therapy time may be given to another client. Please give as much notice as possible for canceled or rescheduled appointments. Since there is most often a waiting list, I can fill cancelations. If you miss the appointment or cancel with **less than 48 hours notice**, you will be charged $75, as I am unable to absorb the lost income and it isn’t fair to the clients in need of help who want to get in but cannot. Please note that insurance companies do not cover/reimburse for missed appointments. As a result, **these charges are the entire responsibility of the client.** I will charge missed appointment on the date of the missed session to the credit card on file. You may cancel by calling 314-808-2346 and leaving a message or sending an email to jschopp@socounseling.com.

**A credit card or debit will be kept on file for all clients.**All information will be kept confidential in a private locked office. All clients must agree to maintain a credit card on file for payment of **all missed appointment fees and any balances past due.**

**Debit/Credit Cards** A convenience fee will be charged as follows.   
**$0-$50** $1.25  **$50.01-$75**$1.75 **$75.01-$100** $2.15 ​**$100.01+**3%​

**Cash and checks are accepted without any associated fees.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Credit Card Information of Financially Responsible Party**

**(Required of all clients regardless of billing or payment arrangements)*.***

Client’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financially Responsible Party’s’ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name on the Credit Card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Credit Card: MasterCard Visa Discover

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: (month/year)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code: (last 3 numbers on back of card)\_\_\_\_\_\_\_\_\_\_\_ Zip Code of billing address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Julia Schopp to process the above credit card as “Signature on File” for any due balance. I understand this authorization will expire upon conclusion of care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Financially Responsible Party Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Witness Printed Name

