Collaborative Marriage & Family Counseling

Mary Beth Harper, LMFT, LPC
1066 Executive Parkway Drive, Suite 103
St. Louis, MO 63021
314-265-9424
mbharper@cmfcounseling.com

Welcome and thank you for taking a few moments to complete this form. The next page will describe what to expect in our work together. At the end of that page, there is a place for your signature. You may inquire about any of the policies before you sign.

Name ____ DOB & Age ________________

Name ____ DOB & Age ________________

Street ______________________________ City _____________________ Zip ____________

Home Phone ____________________________________

Email ___________________________________ Cell Phone ___________________________

Email ___________________________________ Cell Phone ___________________________

Emergency Contact Name & Number ____

Employer(s) ____________________________________Annual Household Income ____________

Education: (circle one) Grade School High School College Graduate School (Name ________)

Education: (circle one) Grade School High School College Graduate School (Name ________)

Race/Ethnicity _________________________ Religious Preference _________________________

Marital Status _________________________ Name & Age of Spouse _______________________

Names & Ages of Children ____

If you currently receive medical treatment for illness, chronic condition, or mental health issue please describe:

If you currently take medication for mental health issues, please list:

Name of Physician, Counselor and Psychiatrist assisting you:

Who referred you to counseling or how did you find Mary Beth Harper? __________________________

Will you consent to Mary Beth sending a thank you note to the referring person? Yes No

Insurance Company _______________________________Fee or Copay _____________________

Authorization Number ____________________ Authorized Visits ________ Deductible ____________

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- **Services:** Include individual, couple, and family therapy for adolescents and adults. Referrals to medical, legal, or other services provided as needed.
- **Scheduling:** Please call at least 72 hours in advance to cancel or reschedule an appointment. If timely notice is not provided, you may be charged the full session fee. Insurance companies do not reimburse for cancellations or no show appointments and you will be responsible for full payment.
- **Crises:** In case of emergency, contact Life Crisis Services at 314-647-4357. If the emergency is life-threatening, call 911 first. You may contact Mary Beth at 314-265-9424 and attempts will be made to return your call within 24hrs.
- **Fees:** The fee is $150 per hour and will be collected at the end of each appointment. A sliding fee scale is offered based on .001% of your annual household income ($150,000 x .001 = $150/session). Fees are negotiable based on need. You may also be charged for lengthy phone calls.
- **Insurance:** If insurance is used for payment of services, please be advised that insurance companies require a mental health diagnosis to determine medical necessity. In signing this consent form, you agree to allow your therapist to release information to the insurance company and billing service in order to process reimbursement.
- **Privacy:** Adherence is made to all state laws and professional ethical standards regarding your privilege of confidentiality. If you want collaboration with a referral source, family member, or other service provider, you will be asked to give your permission in writing. In the unlikely event that there is a danger to someone's life or health, or if there is a suspicion of child abuse, appropriate authorities will be notified. Also, information about your therapy can be subpoenaed by a court of law. You are welcome to review your records with me at your request. If you wish to make copies for yourself or another professional, you will be asked to sign a release form. Your signature below indicates you have received this information.
- **Electronic Communication:** Mary Beth's phone messages and emails are password protected and only viewed/heard by her. Phone messages, texts and emails are used within Mary Beth's practice primarily to conduct logistics of appointments or to convey resources, and **not** to discuss therapeutic matters. Mary Beth does not participate in internet social networking sites with clients.
- **Signature:** Your signature indicates that you understand and accept the above described policies. Your signature gives permission for treatment of any children listed on the first page. Your signature states that you have legal guardianship over the children listed and that you are allowed to seek counseling services for them. Please sign and date your signature.

Client ____ Date _______________

Client ____ Date _______________

Therapist____ Date _______________