Tony Rankin Counseling

D. Tony Rankin MA, LPE
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CLIENT INFORMATION

Client Name: _____ Today's Date: _____

Address: _____ City: _____ State: ____Zip: _____

Billing Address: _____ City: _____ State: ___Zip: _____

Date of Birth: _____ Current Age: _____ Email Address: _____

Home Telephone: _____ Permission to Call: Yes No

Work Telephone: _____ Permission to Call: Yes No

Cell Telephone: _____ Permission to Call: Yes No

Occupation: _____ Employer: _____

Marital Status: Single Married Separated Divorced

Where did you hear about us? Website Online Search Brochure Friend Other: _____

Referral Source: Doctor Counselor Pastor Employer Psychiatrist Other: _____

Name of Referral Source: _____

Are you currently seeing another therapist? _____ If yes, who? _____

List any brain injuries, surgeries, or health problems: _____

List any medications you are currently taking (include dose & frequency): _____

_____

What prompted you to make today's appointment for therapy? _____

What have you done about the problem so far? _____

What do you hope to achieve through counseling? _____

Center Policy

STATEMENT OF TREATMENT
Our purpose is to provide treatment that is appropriate to meet your personal needs and to affect the greatest amount of positive change in the shortest period of time. Our goal is to establish positive, constructive guidance while dealing with specific issues in our clients' lives. Clients may be referred to other facilities or persons for treatment not available at this center.

LEGAL
We are required by law to report all cases of child abuse (physical, emotional, or sexual) to the Children's Protective Services Agency. We are required by law to report all cases of abuse of the elderly, disabled, and/or mentally challenged to the Adult Protective Services Agency. Suicidal clients will be referred for hospitalization and/or medical treatment and a responsible party will be notified. Our counselors may become a part of the legal issues of our clients and will appear in court on behalf of our clients.

FINANCIAL/APPOINTMENTS
Our goal is to provide professional, competent service at the lowest possible cost to our clients. Fees are due and payable at the time the service is performed. Our fee for each session is $110. Fees for participation in group therapy are $41 per session. Each individual, couples, or family session lasts 50-55 minutes. The session can be paid for with cash, check, money order, or debit/credit/HSA card. If you are interested in filing for reimbursement with your insurance company, we will be glad to give you a receipt that you can submit to them. Although our office is on some insurance panels, we do not file insurance claims. We are willing to complete any forms that may help you receive in and out of network reimbursements. Please notify my office of your rescheduling needs at least 24 hours prior to your appointment time. Missed appointments without notification will be charged to your account.

DISCLAIMER
I have read and understand this Policy statement. I agree to abide by its stipulations and enter counseling under the conditions stated above. I have voluntarily sought counseling on my own initiative. I reserve the right to accept or reject the counseling given as I deem appropriate. I understand that the counselor involved in my treatment, and the Center itself assumes no responsibility for me personally, for my behavior, mental/emotional well-being, or physical health. I further state that I am the legal guardian of _____, a minor, and have voluntarily sought and consented to counseling for said minor under this Center Policy as stated herein.

Client: Responsible Party: _____Date: _____

Counselor: _____Date: _____