Ridge Counseling Services

Sean M. Ridge, PhD, LMFT

Contact Information

Client:

Full Name _____

Address _____

_____

Home Phone: (_____) _____

Work/Cell: (_____) _____

Email: _____

Is it OK to:
leave a message at home? ____
leave a message at work/cell? ____
Email appointment information? ____
Text appointment information? ____

Family Member (if present):

Full Name _____

Relationship to Client _____

Home Phone: (_____) _____

Work/Cell: (_____) _____

Email: _____

Is it OK to:
leave a message at home? ____
leave a message at work/cell? ____
Email appointment information? ____
Text appointment information? ____

Background Information

Client		Family Member (if present)
_____	Age	_____
_____	Occupation	_____
_____	Estimated Annual Income	_____
_____	Religious Preference	_____

Briefly describe your reason(s) for seeking help _____

_____

_____

How did you hear about these counseling services? _____

Have you ever consulted a professional counselor before? YES NO

If yes, who? _____ When? _____

Medical Information

	Client	Family Member (if present)
Who is your Primary Care Physician?	_____	_____
List any health problems for which you currently receive treatment	_____	_____
	_____	_____
Are you currently taking any medications?	YES NO	YES NO
If so, which ones?	_____	_____
	_____	_____
	_____	_____

Circle any of the following that are presently causing you difficulty (if additional family members are completing form, use separate colors of ink for indicating problem areas):

Abuse	Divorce	Marriage	Sleep
Alcohol/Drug Use	Education	Memory	Stomach Problems
Ambition	Energy	My Past	Stress
Appetite	Fears	Nervousness	Suicidal Thoughts
Asthma	Finances	Nightmares	Temper
Assertiveness	Food	Parenting	Tiredness
Bowels	Friends	Parents	Ulcers
Career Choices	Guilt	Relaxation	Unhappiness
Children	Headaches	Religion	Work
Confusion	Health Problems	Sadness	Other: _____
Concentration	In-Laws	School	
Dating	Insomnia	Self-Control	_____
Decision Making	Legal Matters	Separation	
Depression	Loneliness	Sexual Problems	_____

Please put a ***** next to the **TWO** items that are causing you the **MOST** difficulty.

Family Information

Names (& ages) of those currently living within client's household:

_____

_____

Other Relevant Family Information

_____

_____

_____

Payment for Services
Payment is due at time of service. Any exception to this must be arranged with the therapist. Failure to provide payment may result in termination of therapy. Insurance billing is not provided by the therapist; however, if the client would like to pursue reimbursement from their insurance company, the therapist will provide an adequate walk-out receipt that can be used for that purpose. In addition, 24 hours notice is expected for cancellations. If 24-hours' notice is not given, the client will be responsible for paying for the cancelled session. Fees may be adjusted on an individual basis due to household size, outside aid received, or other factors. Final agreement on fee will be arranged with Dr. Ridge during the initial session.

Standard Fee: $100/session (45min) Your fee: $_____ (*to be filled in during the initial session)*

Phone Calls and Emergency Situations
If a need should arise between scheduled counseling sessions, clients may contact the therapist via phone to schedule another session. If a phone call becomes lengthy or therapeutic in nature, the therapist may bill in 15-minute increments. In case of an emergency, clients should call 911, local police, or a local hospital.

Client Files & Professional Activity
All client files and records are kept in a secure and confidential setting, as required by Tennessee state law. Clients have the right to request to review their records, and a request for release of client file information must be submitted in writing. All adults participating in treatment must consent to the release of information before any details can be provided. Further, the client agrees to utilize these reports for treatment purposes only and agrees not to request Dr. Ridge's participation in legal or court action. The client understands that Dr. Ridge is provided behavioral health treatment, and establishing the therapist-client relationship prohibits him from providing forensic evaluations, including but not limited to disability, workers' compensation, and dependent custody. If additional professional activity is requested by the client (e.g., a letter stating content/progress of therapy), the therapist may bill in 15-minute increments for all activity associated with this request.

Statement of Legal Liability
Dr. Ridge provides counseling services in multiple locations, including but not limited to the Shalom Healing Center and Johnson University. The owners of the property upon which services are provided are not liable for the services provided; Dr. Ridge is solely responsible for the services provided during the course of treatment, and clients acknowledge this and release the property owners and any/all representatives from any legal responsibility for the services provided.

Statement of Confidentiality
The counseling services provided are completely confidential in so far as the laws of the State of Tennessee allow. Under certain conditions, the right to confidentiality is necessarily violated. Those conditions include: 1) the potential for suicide or homicide on the part of the client; 2) when there is a reason to suspect that physical or sexual abuse has occurred to a child or older adult; and, 3) subpoena or court order by the State of Tennessee. The first two situations require the therapist to report the situation to the appropriate authorities. Additionally, Tennessee State Statute establishes the right of non-custodial parents access to medical records of minors, including behavioral health treatment.

Client Rights and Therapy Considerations
As a client, I understand that there are various types of therapy that may be involved in my treatment. I understand that there are some risks that may be involved, which could range from feeling uncomfortable to more intense reactions. I understand that the purpose of therapy is to help me handle problems/situations in a constructive way, and to grow in my understanding of self and my environment. If at any point I become dissatisfied with treatment, I have the right to discuss this with my therapist and/or terminate therapy. I also understand that my therapist can provide me with information on alternative treatment methods, which may include referral to another therapist or another agency.

Agreement to Participate (all participants over 18-y/o must sign)
In signing below, I understand the conditions listed above and agree to participate in counseling.

_____	_____	_____	_____
Signature	Date	Signature	Date