



CLIENT INFORMATION

2660 Crimson Canyon Dr., Ste. 150 • Las Vegas, NV 89128
 702.480.4891 (Chad) • 702.480.4834 (Pam) • 702.254.9991 (Fax)

Date: _____

Personal Information:

Name: _____

Age: _____ Date of Birth: _____

Address (primary): _____

City

State

Zip

- Who may we thank for this referral? _____

Telephone Contact information:

Please list the numbers where we may contact you.

Home: _____ May a message be left at this number? Yes No

Cell: _____ May a message be left at this number? Yes No

Work: _____ May a message be left at this number? Yes No

Background Information

Highest grade level completed: _____ Special Ed: Yes No

Marital status: Single Married Living with significant other

Divorced Separated Widowed

Length of current significant relationship/marriage: _____

Number of Children: _____ Ages: _____

Identified Race:

African American Asian Caucasian Hispanic Native American Other: _____

Religion:

Baptist Catholic LDS Lutheran Jewish Protestant None Other: _____

Other Household Members:

Name	Age	Relationship to you

If Client is a Minor:

Parent/Legal Guardian's Name(s): _____

Address (primary): _____

City State Zip

What concerns bring you to counseling at this time?

1. _____
2. _____
3. _____

What would you like to gain from counseling?

1. _____
2. _____
3. _____



CONSENT TO TREATMENT & OFFICE POLICY STATEMENT

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Treatment

Treatment will include evaluation, history taking, testing when recommended, assignments for therapeutic goal achievement, treatment planning and consultations. You are expected to play an active role in your treatment. Your progress in therapy may depend much more on what you do between sessions than on what happens in your sessions.

If you and/or I believe that a referral to another professional would be appropriate during the course of our treatment, you will be given referrals for other community agencies and/or private mental health practitioners who may better meet your needs. Treatment is most often terminated by mutual agreement. You may discontinue treatment at any time by notifying me.

Medical issues (e.g., medications or diagnoses) may be discussed during your sessions; however, it should be noted that your counselor is NOT a medical doctor, and that any such discussions pertinent to your medical care should be directed to your physician.

I do not conduct assessments for children with pending custody proceedings.

Appointments

You may call 702.480.4834 to schedule, reschedule, or cancel an appointment. Sessions that are not cancelled 24 hours prior to your scheduled appointment will be assessed a \$50.00 fee. If you miss two or more consecutive appointments, your session time will be made available for another client.

Fees

Fees are due at the end of each session. The following is my list of fees:

Service	Fee
Psychotherapy initial assessment and diagnostic interview	\$125.00
Psychotherapy (50-60 minutes)	\$100.00
Psychotherapy (20-30 minutes)	\$50.00
Telephone consultation (per 15 minutes)	\$25.00
No-show/Last-minute (less than 24 hours) cancellation fee	\$50.00
Outside consultation (e.g., attorney, court, school, etc.)	\$350/hour

It is your responsibility to pay for any services received before you terminate your treatment.

Confidentiality (Privacy of Information)

A record of all evaluation and treatment sessions is kept. This information is confidential. Information about your treatment cannot be shared with anyone (e.g., insurance companies, attorneys, physicians, family members, and others) without your written consent. However, certain laws and ethical standards limit confidentiality of treatment information.

Limits of confidentiality are as follows:

- Signed Release of Information form
- Suspected incidents of child or elder abuse
- Potential danger to self or others
- Breach of contract (small claims court)
- If you are a minor, information can be released to the parent(s)/legal guardian(s); however, limits of this release will be discussed concurrently with the parent(s)/guardian(s) and the minor.
- Periodic consultation with supervisors

Risks/Benefits

Therapy has been demonstrated to help many individuals. Therapy is most effective when you follow through on any “homework” assignments or any other activities that we agree might be helpful. One of the primary risks of therapy is the fact that change sometimes comes quickly and easily, but most often is slow and frustrating. Another risk of therapy is that the process may include discussing problems or events that may evoke unpleasant feelings. If this occurs, please inform me immediately so that these feelings may be addressed in a timely and appropriate manner.

Emergencies

In the case of an emergency, a session will be scheduled as soon as possible if needed. If you have an emergency that occurs after regular business hours, you may call 911 or Montevista, a psychiatric facility that provides 24-hour crisis assistance (702.364.1111).

The Therapeutic Relationship

As a professional I will use my best knowledge and skills to help you. Additionally, I must abide by the rules and standards set forth by my professional licensing and certification Boards. In your best interests, these Boards put limits on the relationship between a therapist and a client, and I will abide by these limits.

My signature below indicates that I have read and understand the nature and limits of the services provided. I agree to voluntarily participate in therapy services and will aid in the formation and completion of a treatment plan.

Note: If client is under the age of 18 years, a parent or legal guardian must sign in addition to the client.

Client Signature

Date

Parent/Guardian Signature (*if required*)

Date

Pamela B. Cross, MS
NCC, MFT Int.

Date



CREDIT CARD AUTHORIZATION FORM

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I, _____, hereby authorize **Pamela B. Cross, MS** to charge my credit card for:

<input checked="" type="checkbox"/> REQUIRED	No-show/Last minute cancellations (less than 24 hours prior to scheduled appointment time)
<input type="checkbox"/> OPTIONAL	Each session as long as therapy continues
<input type="checkbox"/> OPTIONAL	Any outstanding account balance not paid after a month of due date

Credit Card Information

Visa Mastercard

Credit card number: _____ - _____ - _____ - _____

CVV2 Code (Security Code on Back of Card): _____

Expiration date: ____ / ____ - ____

Client information

Name as it appears on the card:	
Billing address:	
City, State, Zip:	
Phone number:	()

My signature below indicates that I voluntarily participate in therapy services and will be responsible for payments and any account balance before I terminate treatment.

Client Signature

Date

Pamela B. Cross, MS
NCC, MFT Int.

Date