CHANGING HOPE COUNSELING
Christine Cantilena Barnes MS, NCC, LPC
therapistcb@gmail.com
770.765.3039 cell

Informed Adult Consent

You have just successfully taken your first steps to pursue an active role in counseling. This can be a major decision with many questions and unsure feelings. This document should help clear up some questions, for it contains valuable information about myself, my professional services, state and federal laws and your rights. If you have any questions regarding this form and need further clarification, please let me know so we can further discuss them.

COUNSELING WITH CHRISTINE CANTILENA BARNES

I view counseling as a process of continued growth. I also believe that counseling can enrich your life. This can be seen through the progress in your physical, spiritual, relational, and mental well-being. I believe that entering into counseling shows willpower, strength and incredible courage. Counseling can help uncover strengths while providing strategies to enhance them. I consider empathy, non-judgmental feelings and trust just a few of my essential fundamentals in counseling. I thank you for the privilege of allowing me to take a journey with you for a better healthy way of living. I earned my undergraduate at Virginia Commonwealth University in Richmond, Virginia and my master's degree at Mercer University in Atlanta, Georgia. I am a Licensed Professional Counselor (LPC), receiving my license in 2015.

I am an active member of the Licensed Professional Counseling Association of GA and the NCCI. I have interned under the renowned Kathy Steel both author and international speaker for Trauma and Dissociation. I have worked for numerous years at Emory University Hospitals (ER) and Peachford Hospital in all 8 units, primarily with children. I earned my Registered Play Therapy after earning 150 hours from various workshops and other training. I am a member of The Association of Play Therapy (APT). My theoretical orientation is Adlerian, Person-Centered and a grounded spiritual based core. I believe in drawing for a variety of these strategies to fit the client best. In addition, I firmly believe that a person is part of a family, community, and other establishments that can influence the client's experience in life. I currently an getting fully certified for Forensic Mental Health Evaluations with the courts. I am certified with EMDR through EMDRIA.

PROFESSIONAL COUNSELING

I am bound by the rules and codes of the following organizations, The Rules of the Georgia Composite Board of Professional Counselors, ACA Code of Ethics (2005) stating, "The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients." A.1.a. (www.counseling.org). Professional counseling has scientifically shown to have many benefits, such as solutions to specific problems, better relationships, and improved health and welfare. There are no guarantees that a client's problems will be remedied by seeking services with me as your counselor. Counseling has both benefits and risks. Risks may include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness.

Because the process of counseling often requires discussing the unpleasant aspects of your life, growth can be difficult for many — therefore, things can feel worse before they get better.

SERVICES OFFERED

I am trained and experienced in counseling adult individuals and children. I provide counseling for a range of issues. I do not prescribe medications. If you or your child requires services at any time that I cannot provide, I will assist in a referral, with your permission.

I primarily assist women and children on an individual basis. I counsel minors in play therapy techniques. The Association for Play Therapy, www.a4pt.org (APT), defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development." Play relieves feelings of stress and boredom, connects us to people in a positive way, stimulates creative thinking and exploration, regulates our emotions, and boosts our ego (Landreth, 2002). In addition, play allows us to practice skills and roles needed for survival. Learning and development are best fostered through play (Russ, 2004).

In the initial session(s), I will gather information about you by taking a personal family history. I will also learn more about the reason you have pursued services with me. After this evaluation session, I will be able to offer you some first impressions of what type of work will be necessary for us to work well together. We will come up with a treatment plan for our future sessions. We will work together to devise a counseling plan that offers reasonable promise of success to meet your abilities and goals. We will regularly review these goals in our process and change them if necessary. At any time, the client has the right to terminate counseling.

APPOINTMENTS AND CANCELLATIONS

A counseling session lasts 50 minutes. To avoid being charged for a scheduled appointment, it must be rescheduled or cancelled at least 24 hours in advance. This can be done by email (therapistcb@gmail.com) & (hopecounseling.mehta@gmail.com or my cell phone is (**770-765-3039)**. A missed appointment is a lost opportunity for both the client and the counselor. The counselor has reserved this time for you, the client. Other clients are not able to obtain that appointment time because it was specifically held for you. In addition, this time was set aside for you as part of your important counseling process. Unforeseen emergencies will be discussed on an individual basis.

I _____, will make every attempt to keep my scheduled appointments. I will make every effort to cancel, when needed, 24 hours in advance.

Date: _____

PROFESSIONAL FEES AND PAYMENT

I charge $175.00 per hour for the initial Intake 50-minute session; Going forward it is $125.00, however, I honor a sliding scale for financially challenged client. Please contact office for further info (couple and family therapy). Payment through check, cash, or credit card is due at the end of each session.

While email is an effective source of communication, I will not provide counseling through email. Telephone consultation can be occasionally beneficial. There is no charge for a brief phone call of ten minutes or less. After ten minutes have elapsed, you will be billed at a prorated rate, based on a 50-minute session and your agreed hourly rate.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully, before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required, even if another party compels me to testify. To attend court, my fee is $500 a day and $125/hour to prepare any documentation, including letters.

CONFIDENTIALITY

Records are maintained for each client. Records may contain the following: identifying information, session notes, any reports from other professionals regarding treatment; any correspondence or other materials that you send me, and copies of any correspondence that I send you. These records are meant to be a working document to both reflect and guide your therapeutic work. **Your records are confidential and only accessed by me unless:**

- Should you choose to seek reimbursement for counseling from your insurance provider.
- I am mandated to report physical harm to yourself such as suicidal ideations.
- I am mandated to report any physical harm you plan to do to someone else, such as homicide
- I am mandated to report any physical or mental harm of a child or elderly person.
- Information necessary for supervision or consultation.
- Information noted by HIPPAA Notice of Privacy Practice.
- Information required by Georgia Law.

Signature _____ Date: _____

EMERGENCIES

While I will always try to return phone calls or emails within 24 hours (or sooner), I would advise to call 911 immediately (for any emergencies) or go directly to the nearest emergency room.

_____

NOTICE OF PRIVACY PRACTICES AND CLIENTS' RIGHTS

I have received a summary of information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Signature: _____ Date: _____

CONSENT FOR TREATMENT OF MINORS

Clients under 18 years of age who are not emancipated, and their guardian, should be aware the law allows parents to examine their child's treatment records, unless (as I understand) that doing so would endanger the child, or we agree otherwise. While privacy in therapy is crucial to successful progress, parental involvement can also be essential. Because privacy in counseling is so critical and I believe the cornerstone of therapy, particularly with teenagers, it is sometimes my policy to request an agreement from the parents that they consent to give up access to their child's records. I can provide general information of the child's progress after sessions. If I uncover something that I think the child needs to tell their parents, I will give them two weeks to tell them.

For this reason, it has often been my policy not to provide treatment to a child under age 13 unless the child agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the child and the parents, allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see above section about confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised (see sample Adolescent Consent Form, to be signed by both adolescent and parent(s).

Signature of Parent:_____ **Date:**_____

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I sent to others, and your billing records.

Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider, at your written request.

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voicemail and your call will be returned as soon as possible, but it may take a day or two for non- urgent matters. If, for any number of unforeseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call (or if you feel unable to keep yourself safe):

(1) contact Community Mental Health Services of Johns Creek (I can provide contact numbers and they are available online as well) or

(2) Go to your local hospital emergency room or

(3) Call 911 and ask to speak to the mental health worker on call.

I will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering my practice.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

CONSENT TO THERAPY and EMDR

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms. I understand that confirm I do not suffer from SEIZURES

Signature of Patient or Personal Representative _____

Printed Name of Patient or Personal Representative_____

Date _____

Description of Personal Representative's Authority_____

I consent to exchange information with any staff nurse practitioners to ensure better medical treatment. Would like permission to speak with other therapists you have seen in the past to maintain high quality treatment and communication.

Patient's Name: _____

Parent's name if Patient is Minor: _____

Date:_____

I AM GIVING CONSENT TO HAVE EMDR (EYE MOVEMENT DESENTIZATION)

Patient Name: _____

Parent's Name if Patient is Minor: _____

Date _____

Therapist _____

Date _____

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Release of Information Consent

Client's name: _____

I authorize _____ to send / receive the following information (Check all that apply):

___ Medical history and evaluation(s)
___ Mental health evaluations
___ Developmental and/or social history
___ Educational records
___ Progress notes, and treatment or closing summary
___ Other _____

To: _____ From: _____

Your Relationship to Client:
Self _____
Parent/ Legal Guardian _____
Personal Representative _____
Other _____

The above information will be used for the following purposes:
___ Planning appropriate treatment or program
___ Continuing appropriate treatment or program
___ Determining eligibility for benefits or program
___ Case review
___ Updating files
___ Other (Specify): _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature: _____ Date: _____

Witness Signature (if client is unable to sign): _____ Witness Date:_____

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INFORMATION, AUTHORIZATION, AND CONSENT TO TELEMENTAL HEALTH

Thank you for choosing the services that I provide. This document is designed to inform you about what you can expect regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to TeleMental Health.

TeleMental Health is defined as follows:
"TeleMental Health means the mode of delivering services via technology -assisted media, such as but not limited to, a telephone, video, internet, smartphone, tablet, PC desktop or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self -management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01)

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, I have completed specialized training in TeleMental Health and I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

Different Forms of Technology-Assisted Media Explained

Telephone via Landline:
It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated the call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline in my office or from my cell phone, typically only regarding setting up an appointment, if needed. If this is not an acceptable way to contact you, please let me know. Telephone conversations (other than setting up appointments) are billed at my hourly rate.

Cell phones:
In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated the call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Telephone conversations (other than setting up appointments) are billed at my hourly rate. Additionally, I keep your phone number in my cell phone, but it is listed by your initials only and my phone is password protected. If this is a problem, please let me know, and we will discuss our options.

Text Messaging:
Text messaging is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text because it is a quick way to convey information.

Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy. Even though we will utilize texting primarily for appointments, I am willing to text for DBT concerns.

Email:
Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication for appointment confirmations and quick DBT questions or check-ins.** Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Blog:
It is my policy not to accept "friend" or "connection" requests from any current or former client on my **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc., because it may compromise your confidentiality and blur the boundaries of our relationship.

Video Conferencing (VC):
Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA).

Website Portal:
I have a client portal that is accessible through my website at changinghopecounseling.com, which is powered by Weebly. Changing Hope Counseling provides forms that can be printed prior to appointments.

Recommendations for Other Websites or Applications:
During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information provided as an adjunct to your treatment or if you prefer that I do not make these recommendations. Please let me know by checking (or not checking) the appropriate box at the end of this document.

Electronic Transfer of PHI for Billing Purposes:
If I am credentialed with and a provider for your insurance, please know that I utilize a billing service who has access to your PHI.

Electronic Transfer of PHI for Certain Credit Card Transactions:
I utilize the company ROAMPAY for processing credit card information. This company may send the cardholder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways — either upon your request or at the time the card is processed. Please be aware that it is your responsibility to know if you or the cardholder has an automatic receipt notification set up in order to maintain your confidentiality, if you choose not to receive receipts via text or email.

Your Responsibilities for Confidentiality and Tele-Mental Health:
Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

Communication Response Time:
I am required to make sure that you are aware that I am located in the Southeast and I abide by Eastern Standard Time. My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. I will return texts and emails within 24 hours. However, I do not return calls on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency:

- If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:
- Call Behavioral Health Link/GCAL: 800.715.4225
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589
- Call Lifeline at 800.273.8255 (National Crisis Line)
- Call 911
- Go to the emergency room of your choice

Emergency Procedures Specific to TeleMental Health Services:
There are additional procedures that need to be in place specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and TeleMental Health services will not be appropriate.
- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your ECP here:

Name: _____ Phone: _____

- You agree to inform me of the address where you are conducting every TeleMental Health session.
- You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session).

Please list this hospital and contact number here:

Hospital: _____ Phone: _____

In Case of Technology Failure:
During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and I have that phone number. If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to *my* phone service, and we are not able to reconnect, I will not charge you for that session.

Structure and Cost of Sessions:
I offer primarily face-to-face counseling. However, based on your ability to make in-person sessions, I may provide phone, text, or email. If your treatment needs determine that TeleMental Health services are appropriate for you, then you may engage in either face-to-face sessions, TeleMental Health, or both. We will discuss what is best for you.

Payment is due at the time of your session — we accept Visa, MasterCard, Discover, American Express, cash, or check. A receipt of payment and the services provided will be given to you. The receipt of payment and services completed may also be used as a statement for insurance if applicable to you (see below) . Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, many do not cover TeleMental Health services. Unless otherwise negotiated, it is your responsibility to find out if your insurance company processes insurance reimbursement for TeleMental Health services. As stated above, I will be glad to provide you with a statement for your insurance company and to assist with any questions you may have in this area.

You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet/phone charges, software, headset, etc.

Cancellation Policy:
In the event that you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

Limitations of TeleMental Health Therapy Services:
TeleMental Health services should not be viewed as a complete substitute for therapy conducted in my office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that I could easily pick up if you were in my office.

There may also be a disruption to the service (e.g., phone disconnection, video drops) . This can be frustrating and interrupt the normal flow of personal interaction. Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I have done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm.

Face-to Face Requirement:
If we agree that TeleMental Health services are the primary way to conduct sessions, I require one face-to-face meeting at the onset of treatment and prefer for this initial meeting to take place in my therapy office. If that is not possible, we can utilize video conferencing as described above. During this initial session, I will require you to show a valid picture ID and another form of identity (such as a credit card in your name) . At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.

Consent to TeleMental Health Services:
Please check the TeleMental Health services you are authorizing me to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment simply by notifying me in writing. If you do not see an item discussed previously in this document listed for your authorization below, this Is because it is built-in to my practice, and I will be utilizing that technology unless otherwise negotiated by you.

Please check one or more:

Email: _____
Texting: _____
Video Conferencing: _____
Website Portal: _____
Electronic Chat Forum:_____
Recommendations to Websites or Apps: _____

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any thoughts or feelings you have about these and other modalities of communication and treatment.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing me to utilize the TeleMental Health methods discussed.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

Office Use:
My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

Therapist's Signature: _____ Date: _____

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INSURANCE VERIFICATION FORM

Name of Patient: _____

Patient Address: _____

Patient Date of Birth: _____

Phone Number: _____

Insurance Company Name: _____

Insurance ID Number: _____

Group Number: _____

If Patient is a Minor

Name of Primary Insured: _____

Insured Relationship to Patient: _____

Insured Employee Name: _____

Insured Phone Number: _____

Insured address: _____

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COURT FEES AGREEMENT

I _____, promise to pay my account in good faith at the time when I enter into a court situation. I understand that I must in advance of my court date.

I understand that if I need Christine Cantilena Barnes for court appearances or to prepare letters/documentation (in response to subpoenas, court orders, phone conversations with DFCS or lawyers, etc.), that I will pay 125.00 an hour to prepare and $800.00 for a day in court. Initials ___

I agree to pay on my credit card that I have supplied on Credit Card Agreement form.

Client's Signature: _____

Parent's Signature if Client is Minor: _____

Date: _____

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NO SHOW AGREEMENT

I,_____, promise to pay my account in good faith at the time when **NO SHOW** for my appointment. I understand that I must cancel **24 hours** in advance to be respectful for others that may be on a waitlist. If I do not show up for my appointment or call 24 hours in advance, I am responsible for paying a $75.00 fee. Changing Hope Counseling has right to charge to my credit card the fee of $75.00. If they are unable to charge, I will be unable to return for future therapy sessions until the fee is paid by phone or in person, prior to my next appointment.

Failure to show up or call 24 hours in advance, I will be responsible for paying a $50.00 fee and agree to leave my credit card information below to facilitate payment. Initials ___

I understand that if I need Christine Cantilena Barnes for court appearances or to prepare letters/documentation (in response to subpoenas, court orders, phone conversations with DFCS or lawyers, etc.), that I will pay 125.00 an hour and $500.00 in advance. Initials ___

I agree to pay on my credit card that I have supplied on Credit Card Agreement form.

Client's Signature: _____

Parent's Signature if Client is Minor: _____

Date: _____

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Credit Card Agreement

Authorization use of Master Card, Visa, American Express, Discover or any other card.

Client Name: _____

I hereby authorized Christine Cantilena Barnes MS, NCC, LPC (Changing Hope Counseling) to charge any unpaid balance for professional services render, to my credit card, as follow.

__MasterCard __Visa __ American Express __Discover __ Other

Card Number: _____

Expiration Date: _____

CVV code (3 digit on back or 4 digit on front of American Express):
_____

Name as appears on my card: _____

Billing Address: _____
City: _____
State and Zip: _____

Client Signature (guardian signature if patient is a minor):
_____

Date: _____