The Art of Relationships, PLLC

Counseling for Couples, Adults, & Families

Client Information

Client's Name: _____ **D.O.B.** _____ **F:**____ M: _____

Address: _____

Telephone: _____ **Email:** _____

Single ____ **Married**____ **Dating**____ **Co-Habitating**____ **Engaged**____**Separated**_____**Divorced**____**Widowed**____

Partner or Spouses Name: _____ **D.O.B.** _____ **F:** ___ M:____

Address: _____

Telephone: _____ **Email:** _____

Reason for seeking assistance: _____

_____

Referred By: _____

Insurance Information: * **(only if insurance is being used)**

Carrier: _____ **Member ID#:** _____ **Group #:** _____

Contract #: _____ **Name Under:** _____

Carrier Phone #: _____

Current Medications and/or Medical Conditions: Client:_____

_____**Partner:** _____

Emergency Contact Name:_____

Relationship:_____ **Phone:** _____

17368 W. Twelve Mile Road, Suite 201, Southfield, MI 48076
(313) 614-9498 / Email: greg@theartofrelationships.org

Previous counseling, psychiatric treatment:

Agency_____

Therapist/Dr. Name_____

Date_____

Client's Physician Name: _____

Address :_____

Phone:_____

Please read the information below and sign your name in the spaces provided. Should you have any questions, please feel free to discuss any of these issues with the receptionist or your therapist before signing.

Client's Rights and Responsibilities:

As a client, you have certain rights: You have the right to know our assessment of the problem, the recommended treatment plan, and resources available to help improve this problem.

-You have the right to refuse treatment. Even though your counselor may strongly suggest you seek help, you may choose to not follow the counselor's advice. Should you choose to refuse treatment, you will be advised of the consequences that may result from your refusal. Alternative forms of treatment or help may be available.

Along with these rights go certain responsibilities. These are: To be honest, open and willing to share your concerns with your counselor To ask questions when you do not understand or need clarification. To discuss any reservations you have about your treatment plan with your counselor

To follow the agreed upon treatment plan . To report changes or unexpected events as related to your problem with your counselor.

Fees: Standard fees are $80 for each individual session (45-50 minutes)

Cancellations and Missed Appointments: As the time reserved for your appointment is your time, please give

24 hour notification. If it is necessary to cancel an appointment. There will be a $30 charge for any missed or late canceled appointment. Payment: Payment or copayment is due at the time of your appointment.

Confidentiality

Information shared with your therapist is confidential unless you have signed a release. According to the law, the following may be shared without a signed consent: observed or suspected child abuse, elder abuse, prevention of bodily harm to yourself or to another person, any information subpoenaed by court or otherwise necessary to the administration of justice, filing an insurance claim, breach of contract (small claims court), if a client is a minor, or the client experiences an emergency requiring information from the client 's record to be given to another health care provider or for other reasons which can be explained by the therapist. Consent for Treatment: I have completely read this form and certify that I am the client, or the client's parent or guardian. I authorize my therapist to administer and perform treatment and diagnostic procedures that may now or during the course of treatment be deemed advisable or necessary.

_____

Signature of client (Parent or Guardian if under 18 years of age) Date

Statement of Financial Responsibility: I understand that even though I may have insurance coverage, I am responsible for payment. I agree to the terms of this payment policy

_____

Signature of client (Parent or Guardian if under 18 years of age) Date

Court or Subpoena Clause:

I have received a copy of my rights. I understand that a copy of the Michigan Mental Health Code is available to me for my review. I have had explained to me the process on how I may report violations to The Art of Relationships, PLLC or Greg Dudzinski, MS, LPC rights advisor and seek their assistance, and that this information is provided in writing upon request. Also, complaints may be filed with the State of Michigan at:

Michigan Department of Consumer and Industry Services
Complaint and Allegation Division, P.O. Box 30670, Lansing, MI 48909, (517) 373-9196.

I understand that should I or a third party subpoena Greg Dudzinski, MS, LPC as a factual case witness or involve him in court-related processes, he will charge me a retainer fee of $1,500, and a charge of $250.00 every hour he is involved in case preparation, research, paper work, phone calls, travel, and witness time.

I understand that if I do issue Greg Dudzinski, MS, LPC a subpoena with or without his approval (see above) that my subpoena may be directly turned over to his attorney and a bill will be rendered for an immediate attorney's retainer fee. I will also be billed accordingly by him and I agree to pay all attorney's fees plus my therapist's fees as invoiced.

I understand that if a minor who is in therapy has parents who are divorced and/or part of a joint custody agreement, I must furnish Greg Dudzinski, MS, LPC with a copy of the custody agreement.

Client's Signature _____ Date _____

Partner's Signature _____ Date _____

Greg Dudzinski, MS, LPC _____ Date _____