Rosewood
Mental Health Services

Gortanummera
Portumna
Co. Galway
091 423 798

Thank you for inquiry regarding services with Rosewood Mental Health Services. Typically we initially set up a consultation session in which we can attain a better understanding of you, and your goals and share with you the things we have to offer that might address the concerns or issues that you would like to work on.

There is no charge for this initial session and it provides an opportunity to get to know each other. Please fill out the form(s) that are appropriate for the age group; one for each member of the family, or couple. (Print additional forms if needed) These forms will help present an overview of your past and present experiences. If you find that a particular question is uncomfortable to answer, that is OK and very normal but try to do so anyway, however if find you just can't answer, write "NA" for the answer; that way I will know that you did not miss seeing the question.

Please review the *Therapeutic Contract* which will cover the structure and expectations of the therapeutic process. Also, please read the *No Secrets Policy* and the *Fees* schedule.

If you have any questions, you are encouraged to write them down and bring with you to the consultation and we can, together, address them there.

Thank You,

Don Corrington

Don Corrington

Rosewood
Mental Health Services

CLIENT INFORMATION: (Child 11 and under – to be completed by parent or guardian)

Name:_____ _____ _____
Last First MI

Sex [ ] Male [ ] Female DOB: _____ EMAIL: _____

House Name or House Number _____

Street Name _____

City or Town _____ Postal Code: _____ _____

Home Phone _____ Mobile Phone _____

EMAIL: _____

Is your child currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? [ ] Yes [ ] No

Has your child had previous psychotherapy? [ ] Yes [ ] No

Previous therapist's name_____

Is your child currently taking prescribed psychiatric medication (antidepressants or others)? [ ] Yes [ ]No

If Yes, please list: _____

If no, has your child been previously prescribed psychiatric medication? [ ] Yes [ ] No

If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

How is your child's physical health at present? (Please check one)

[ ] Poor [ ] Unsatisfactory [ ] Satisfactory [ ] Good [ ] Very Good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

_____

_____

Is your child having any problems with their sleep habits? [ ] Yes [ ] No
If yes, check where applicable:

[ ] Sleeping too little
[ ] Disturbing dreams
[ ] Sleeping too much
[ ] Poor quality sleep
[ ] Other _____

How many times per week does your child exercise? _____

Approximately how long each time? _____

Is your child having any difficulty with appetite or eating habits? [ ] Yes [ ] No
If yes, check where applicable:

[ ] Eating less [ ] Eating more [ ] Binging [ ] Restricting

Has your child experienced significant weight change in the last 2 months? [ ] No [ ] Yes

Does your child use alcohol? [ ] No [ ] Yes

Does your child engage recreational drug use?

[ ] Daily [ ] Weekly [ ] Monthly [ ] Rarely [ ] Never

Has your child had suicidal thoughts recently?
[ ] Frequently [ ] Sometimes [ ] Rarely [ ] Never

Has your child had them in the past?
[ ] Frequently [ ] Sometimes [ ] Rarely [ ] Never

In the last year, has your child experienced any significant life changes or stressors:

_____

_____

HAS YOUR CHILD EVER EXPERIENCED ANY OF THE FOLLOWING:

Extreme depressed mood	[ ] Yes [ ] No	Unexplained losses of time	[ ] Yes [ ] No
Wild Mood Swings	[ ] Yes [ ] No	Unexplained memory lapses	[ ] Yes [ ] No
Rapid Speech	[ ] Yes [ ] No	Alcohol/Substance Abuse	[ ] Yes [ ] No
Extreme Anxiety	[ ] Yes [ ] No	Frequent Body Complaints	[ ] Yes [ ] No
Panic Attacks	[ ] Yes [ ] No	Eating Disorder	[ ] Yes [ ] No
Phobias	[ ] Yes [ ] No	Body Image Problems	[ ] Yes [ ] No
Sleep Disturbances	[ ] Yes [ ] No	Hallucinations	[ ] Yes [ ] No
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	[ ] Yes [ ] No	Repetitive Thoughts (e.g., Obsessions)	[ ] Yes [ ] No
Homicidal Thoughts	[ ] Yes [ ] No	Suicide Attempt	[ ] Yes [ ] No

RELIGIOUS / SPRITUAL INFORMATION:

Do you consider your child to be religious? [ ] Yes [ ] No

If yes, what is their faith? _____

If no, do you consider your child to be spiritual? [ ] Yes [ ] No

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (mark any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty in Family Members:

Depression	[ ] Yes [ ] No	_____
Bipolar Disorder	[ ] Yes [ ] No	_____
Anxiety Disorders	[ ] Yes [ ] No	_____
Panic Attacks	[ ] Yes [ ] No	_____
Schizophrenia	[ ] Yes [ ] No	_____
Alcohol/Substance Abuse	[ ] Yes [ ] No	_____
Eating Disorders	[ ] Yes [ ] No	_____
Learning Disabilities	[ ] Yes [ ] No	_____
Trauma History	[ ] Yes [ ] No	_____
Suicide Attempts	[ ] Yes [ ] No	_____

OTHER INFORMATION:

What do you consider to be your child's strengths?_____

_____

What do you like most about your child?_____

_____

What are your goals for therapy?_____

_____

_____

INDIVIDUAL APPOINTMENTS:
The Initial Family Assessment session can last up to 90 minutes and the fee is usually €60. Each subsequent session is 50 minutes and the fee is €40 and is prorated at 30 minute intervals for sessions longer than 50 minutes. The session ends at the appointed time and is considered a full session even if the client is late.

PAYMENT OF FEES:
Fees are to be paid at the time of service. Payment may be made by cash or check. Credit card payment may be made through the use of PayPal.

IN THE CASE OF A MINOR CHILD:
I have given a truthful and accurate medical history of my child so that enough pertinent information exists in order to make the best professional judgment possible as to a treatment plan.

I have read this agreement, understand it and agree to comply with it.

Signature_____Date_____

Rosewood
Mental Health Services

CLIENT INFORMATION: (Client age 12-17. To be completed by individual)

Name:_____ _____ _____
Last First MI

Sex [ ] Male [ ] Female DOB: _____ EMAIL: _____

House Name or House Number _____

Street Name _____

City or Town _____ Postal Code: _____ _____

Home Phone _____ Mobile Phone _____

EMAIL: _____

Marital status:

[ ] single, never married
[ ] engaged ___ months
[ ] married for __ years
[ ] divorced for __ years
[ ] separated for _____ years
[ ] divorce in process _____ months
[ ] live-in for _____ years
[ ] ____ prior marriages (self)
[ ] ____ prior marriages (partner)

Relationship satisfaction:

[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship
[ ] not in a relationship

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? [ ] Yes [ ] No

Have you had previous psychotherapy? [ ] Yes [ ] No

Previous therapist's name_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? [ ] Yes [ ]No

If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication? [ ] Yes [ ] No

If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

How is your physical health at present? (Please check one)

[ ] Poor [ ] Unsatisfactory [ ] Satisfactory [ ] Good [ ] Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

_____

_____

Are you having any problems with your sleep habits? [ ] Yes [ ] No
If yes, check where applicable:

[ ] Sleeping too little
[ ] Disturbing dreams
[ ] Sleeping too much
[ ] Poor quality sleep
[ ] Other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? [ ] Yes [ ] No
If yes, check where applicable:

[ ] Eating less [ ] Eating more [ ] Binging [ ] Restricting

Have you experienced significant weight change in the last 2 months? [ ] No [ ] Yes

Do you regularly use alcohol? [ ] No [ ] Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage recreational drug use?

[ ] Daily [ ] Weekly [ ] Monthly [ ] Rarely [ ] Never

Have you had suicidal thoughts recently?
[ ] Frequently [ ] Sometimes [ ] Rarely [ ] Never

Have you had them in the past?
[ ] Frequently [ ] Sometimes [ ] Rarely [ ] Never

In the last year, have you experienced any significant life changes or stressors:

_____

_____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:

Extreme depressed mood	[ ] Yes [ ] No	Unexplained losses of time	[ ] Yes [ ] No
Wild Mood Swings	[ ] Yes [ ] No	Unexplained memory lapses	[ ] Yes [ ] No
Rapid Speech	[ ] Yes [ ] No	Alcohol/Substance Abuse	[ ] Yes [ ] No
Extreme Anxiety	[ ] Yes [ ] No	Frequent Body Complaints	[ ] Yes [ ] No
Panic Attacks	[ ] Yes [ ] No	Eating Disorder	[ ] Yes [ ] No
Phobias	[ ] Yes [ ] No	Body Image Problems	[ ] Yes [ ] No
Sleep Disturbances	[ ] Yes [ ] No	Hallucinations	[ ] Yes [ ] No
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	[ ] Yes [ ] No	Repetitive Thoughts (e.g., Obsessions)	[ ] Yes [ ] No
Homicidal Thoughts	[ ] Yes [ ] No	Suicide Attempt	[ ] Yes [ ] No

OCCUPATIONAL INFORMATION:

Are you currently employed? [ ] No [ ] Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

_____

RELIGIOUS / SPRITUAL INFORMATION:

Do you consider yourself to be religious? [ ] Yes [ ] No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? [ ] Yes [ ] No

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (mark any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty in Family Members:

Depression	[ ] Yes [ ] No	_____
Bipolar Disorder	[ ] Yes [ ] No	_____
Anxiety Disorders	[ ] Yes [ ] No	_____
Panic Attacks	[ ] Yes [ ] No	_____
Schizophrenia	[ ] Yes [ ] No	_____
Alcohol/Substance Abuse	[ ] Yes [ ] No	_____
Eating Disorders	[ ] Yes [ ] No	_____
Learning Disabilities	[ ] Yes [ ] No	_____
Trauma History	[ ] Yes [ ] No	_____
Suicide Attempts	[ ] Yes [ ] No	_____

OTHER INFORMATION:

What do you consider to be your strengths? _____

_____

What do you like most about yourself?_____

_____

What are effective coping strategies that you've learned? _____

_____

What are your goals for therapy?_____

_____

_____

APPOINTMENTS:
The Initial Assessment session can last up to 90 minutes and each subsequent session is 50 minutes. The session ends at the appointed time and is considered a full session even if the client is late.

CLIENT HISTORY:
I have given a truthful and accurate medical history so that enough pertinent information exists in order to make the best professional judgment as to a treatment plan. I understand that because each person is different, there is no method for determining the number of sessions that will be necessary to resolve the issues as described.

I have read this agreement, understand it and agree to comply with it.

Signature_____Date_____

Rosewood
Mental Health Services

CLIENT INFORMATION: (Client age 18 and above. To be completed by individual)

Name:_____ _____ _____
Last First MI

Sex [ ] Male [ ] Female DOB: _____ EMAIL: _____

House Name or House Number _____

Street Name _____

City or Town _____ Postal Code: _____ _____

Home Phone _____ Mobile Phone _____

EMAIL: _____

Marital status:

[ ] single, never married
[ ] engaged ___ months
[ ] married for __ years
[ ] divorced for __ years
[ ] separated for _____ years
[ ] divorce in process _____ months
[ ] live-in for _____ years
[ ] ____ prior marriages (self)
[ ] ____ prior marriages (partner)

Relationship satisfaction:

[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? [ ] Yes [ ] No

Have you had previous psychotherapy? [ ] Yes [ ] No

Previous therapist's name_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? [ ] Yes [ ]No

If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication? [ ] Yes [ ] No

If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

How is your physical health at present? (Please check one)

[ ] Poor [ ] Unsatisfactory [ ] Satisfactory [ ] Good [ ]Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

_____

_____

Are you having any problems with your sleep habits? [ ] Yes [ ] No
If yes, check where applicable:

[ ] Sleeping too little
[ ] Disturbing dreams
[ ] Sleeping too much
[ ] Poor quality sleep
[ ] Other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? [ ] Yes [ ] No
If yes, check where applicable:

[ ] Eating less [ ] Eating more [ ] Binging [ ] Restricting

Have you experienced significant weight change in the last 2 months? [ ] No [ ] Yes

Do you regularly use alcohol? [ ] No [ ] Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage recreational drug use?

[ ] Daily [ ] Weekly [ ] Monthly [ ] Rarely [ ] Never

Have you had suicidal thoughts recently?
[ ] Frequently [ ] Sometimes [ ] Rarely [ ] Never

Have you had them in the past?
[ ] Frequently [ ] Sometimes [ ] Rarely [ ] Never

In the last year, have you experienced any significant life changes or stressors:

_____

_____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:

Extreme depressed mood	[ ] Yes [ ] No	Unexplained losses of time	[ ] Yes [ ] No
Wild Mood Swings	[ ] Yes [ ] No	Unexplained memory lapses	[ ] Yes [ ] No
Rapid Speech	[ ] Yes [ ] No	Alcohol/Substance Abuse	[ ] Yes [ ] No
Extreme Anxiety	[ ] Yes [ ] No	Frequent Body Complaints	[ ] Yes [ ] No
Panic Attacks	[ ] Yes [ ] No	Eating Disorder	[ ] Yes [ ] No
Phobias	[ ] Yes [ ] No	Body Image Problems	[ ] Yes [ ] No
Sleep Disturbances	[ ] Yes [ ] No	Hallucinations	[ ] Yes [ ] No
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	[ ] Yes [ ] No	Repetitive Thoughts (e.g., Obsessions)	[ ] Yes [ ] No
Homicidal Thoughts	[ ] Yes [ ] No	Suicide Attempt	[ ] Yes [ ] No

OCCUPATIONAL INFORMATION:

Are you currently employed? [ ] No [ ] Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

_____

RELIGIOUS / SPRITUAL INFORMATION:

Do you consider yourself to be religious? [ ] Yes [ ] No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? [ ] Yes [ ] No

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (mark any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty in Family Members:

Depression	[ ] Yes [ ] No	_____
Bipolar Disorder	[ ] Yes [ ] No	_____
Anxiety Disorders	[ ] Yes [ ] No	_____
Panic Attacks	[ ] Yes [ ] No	_____
Schizophrenia	[ ] Yes [ ] No	_____
Alcohol/Substance Abuse	[ ] Yes [ ] No	_____
Eating Disorders	[ ] Yes [ ] No	_____
Learning Disabilities	[ ] Yes [ ] No	_____
Trauma History	[ ] Yes [ ] No	_____
Suicide Attempts	[ ] Yes [ ] No	_____

OTHER INFORMATION:

What do you consider to be your strengths?_____

_____

What do you like most about yourself?_____

_____

What are effective coping strategies that you've learned?_____

_____

What are your goals for therapy?_____

_____

_____

INDIVIDUAL APPOINTMENTS:
The Initial Assessment session can last up to 90 minutes and the fee is usually €60. Each subsequent session is 50 minutes and the fee is €40 and is prorated at 30 minute intervals for sessions longer than 50 minutes. The session ends at the appointed time and is considered a full session even if the client is late.

PAYMENT OF FEES:
Fees are to be paid at the time of service. Payment may be made by cash or check. Credit card payment may be made through the use of PayPal.

CLIENT HISTORY:
I have given a truthful and accurate medical history so that enough pertinent information exists in order to make the best professional judgment as to a treatment plan. I understand that because each person is different, there is no method for determining the number of sessions that will be necessary to resolve the issues as described in the Face Sheet and Presenting Problem section.

IN THE CASE OF A MINOR CHILD:
I have given a truthful and accurate medical history of my child so that enough pertinent information exists in order to make the best professional judgment possible as to a treatment plan.

I have read this agreement, understand it and agree to comply with it.

Signature_____Date_____

Rosewood
Mental Health Services

Therapeutic Contract

Probable Length of Services: Although some clients elect to pursue long-term, in-depth treatment, many issues can be resolved within 12-24 sessions. The success of any treatment depends on the motivation, willingness and dedication of the person being treated. For this reason, no guarantees can be made about treatment length or success.

Risk of Services: Therapy is a process in which the therapist and client discuss a myriad of experiences, memories and issues for the purpose of creating positive change so the client can experience his/her life more fully. It provides an opportunity to better and more deeply understand oneself, as well as, any problems or difficulties that he/she may be experiencing. It is a joint effort between client and therapist. Progress and success may vary depending upon the particular problems being addressed, as well as other factors. You should also know that therapy is intended to induce change in your life and when this change occurs it may disrupt your accustomed manner of living and your relationships. During the therapeutic process, many clients find that they feel worse before they feel better. This is pretty normal. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. The client should discuss any concerns he/she has regarding his/her progress with the therapist.

Therapeutic Approach: My approach to therapy is both cooperative and collaborative, and individualized. The following therapeutic approaches may be used:

1. **Counselling** which is a process where, by talking to someone specially trained to listen attentively about how you're feeling, you can work out, or try to change, the things that cause you distress. At any time, individuals, couples or families can be confronted by uncertainties and life experiences which threaten to exhaust emotional and spiritual resources. The loss of a loved one, parent-teen conflict, loss of job or the care of an elderly parent are just a few of life's transitions and crises that can be depleting. Counselling can help you think about, address and resolve issues which are causing difficulty in your life. It can involve identifying options and choosing between them, learning new skills to cope better with problems, gaining greater understanding of what is occurring, or being supported while recovering from some significant life event.

2. **Cognitive Behavioral Therapy** which focuses on thought patterns, perceptions of events/self/others, emotions linked up to those thoughts/perceptions and finally the behaviors that result.

3. Family Systems which focuses on understanding the patterns and communication styles present in your current and past relationships, as well as the roles you play within those relationships. We will also review how one person's growth can effect change in the entire system, even when the others are not participating in the treatment. This is why not all members of a system need to be present to address relationship issues.

4. Eye Movement Desensitization and Reprocessing (EMDR) which involves recalling a stressful past event and "reprogramming" the memory in the light of a positive, self-chosen belief, while using rapid eye movements to facilitate the process.

Your Rights: Treatment is entirely voluntary, and you have the right to terminate at any time. I have the right to terminate therapy with you under the following conditions:

1. I believe that therapy is no longer beneficial to you.
2. If you fail to follow recommended treatment repeatedly.
3. I believe that you will be better served by another professional.
4. You have not paid for at least two sessions, unless there have been arrangements made.
5. If you have failed to show up for two sessions without a 24 hour notice.
6. If you fail to comply with the 24 hour clean/sober policy for more than two sessions.
7. If you are seeing another Therapist and participating in treatment with me would jeopardize your work with that therapist. *(If you are seeing another therapist I will require that you sign a consent form to release information so communication with the other therapist can occur.)*

Limits of Confidentiality: All information that you disclose to me in our session is confidential and will not be revealed to anyone without your written permission (parents if under 18) except for the following reasons:

1. Where there is reasonable suspicion of child abuse, dependent adult abuse or elder adult abuse.
2. If you reveal to me that an alleged perpetrator is in contact with minors and there is reasonable suspicion that he or she may still be abusing minors.
3. Where there is a reasonable suspicion that you may present a danger of violence to others.
4. Where there is reasonable suspicion that you are likely to harm yourself unless protective measures are taken.

In all the above cases, the psychotherapist is either allowed or required by law to break confidentiality in order to protect you, or someone you might endanger, from harm.

5. I can release all or portions of your records to any person or entity you specify. I will inform you whether or not I think that releasing that information to that agency or person might be harmful to you.

Records: Your file will consist of (a) legal forms such as this document (b) a record of visits and payments, and (c) clinical progress notes which contain enough information to justify your treatment, should that ever need to be justified.
You have the right to view your records, and should make that request in writing.
I reserve the right to provide you with the complete records or a summary of their content.

In all cases therapy never includes sexual contact or conduct between therapist and client.

Cancellations or Late Arrivals: Since an appointment reserves time specifically for you, a minimum of 24-hour notice is required for cancellation and rescheduling an appointment. Outside of an agreed upon emergency or accident, the full fee will be charged. Additionally, if you are late, we will meet for whatever amount of our time remains and you will be charged for the full session.

Telephone calls: You are welcome to leave messages at any time regarding a therapeutic issue. You should receive a call back within 24 hours if it is an emergency or accident and within 48 hours if it is not (please leave message briefly stating the nature of the call). Remember that, in general, telephone calls are not meant to take the place of an office visit; if you require extended time (15 minutes+) on the phone you will be billed for the time. In some special circumstances, treatment may be provided over the phone at the same hourly rate as your office visits.

24-Hour Clean and Sober Policy: Clients are expected to remain sober for 24 hours prior to our session. Any session may be terminated any session if it is believed that a client is under the influence or has used substances within the past 24 hours that impairs his/her ability to participate in treatment. If the session is terminated due to substance use, it is considered a no-show and the client will be charged a fee equal to the regular session fee.

E-mail: The use of e-mail with established clients is discouraged because of the risk it poses to confidentiality.

Text Messaging: Text messaging is not confidential and has no therapeutic or interpersonal benefit in the counseling process, therefore, the use of text messaging is strongly discouraged. ***No correspondence with you through texting, for any reason, will occur; even if you are just cancelling an appointment. If you leave a text message to cancel an appointment, it will be considered a no show. Please call directly and leave a voicemail message.***

Payment for Service: Sessions are charged in accordance with the fee schedule associated with the type of therapy you receive. A therapeutic hour is 50 minutes. You are expected to

pay for services at the time they are rendered unless other arrangements have been made. Please notify Rosewood Mental Health Services ahead of time if any problem arises regarding your ability to make timely payment. Cash, cheque or credit card (though Paypal) are accepted.

I, _____ agree to be legally responsible for any charges that said persons listed hereinafter may incur during psychotherapy with Rosewood Mental Health Services.

_____	_____	___/___/____
Client Name	Client Signature	Date Signed (DD/MM/YYYY)

I understand that I, personally, will be billed for any missed or cancelled appointments (without 24-hour notice). _____ *(initial here)*

Consent for Treatment: (Please print all names of any person or persons participating in therapy, then have each member over the age of 12 sign and date next to it.)

_____	_____	___/___/____
Client Name	Client Signature	Date Signed (DD/MM/YYYY)
_____	_____	___/___/____
Client Name	Client Signature	Date Signed (DD/MM/YYYY)
_____	_____	___/___/____
Client Name	Client Signature	Date Signed (DD/MM/YYYY)
_____	_____	___/___/____
Client Name	Client Signature	Date Signed (DD/MM/YYYY)
_____	_____	___/___/____
Client Name	Client Signature	Date Signed (DD/MM/YYYY)
_____	_____	___/___/____
Client Name	Client Signature	Date Signed (DD/MM/YYYY)

I, the above, authorize and request that Rosewood Mental Health Services carryout psychotherapeutic examinations, diagnostic procedures, and/or treatment for me while I am a client. I understand that the purpose of any procedure will be fully explained and subject to my agreement.

I have read, understand and fully agree with the terms and policies of this therapeutic contract.

_____	_____	___/___/____
Therapist/Witness (printed name)	Signature	Date Signed

Rosewood
Mental Health Services

"No Secrets" Policy
For
Family Therapy and Couple Therapy

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the client. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit — that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the client (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____(couple/family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Don L. Corrington (the therapist), and that we enter couple/family therapy in agreement with this policy.

(If someone is signing in a representative capacity, such as a parent or a court-appointed guardian or conservator, such capacity should be stated and the person being represented should be specified.)

_____

Name of Client (please print)

_____

(please sign)

Date: ___/___/___

_____

Name of Client (please print)

_____

(please sign)

Date: ___/___/___

_____

Name of Client (please print)

_____

(please sign)

Date: ___/___/___

_____

Name of Client (please print)

_____

(please sign)

Date: ___/___/___

_____

Name of Client (please print)

_____

(please sign)

Date: ___/___/___

_____

Name of Client (please print)

_____

(please sign)

Date: ___/___/___

_____

Name of Client (please print)

_____

(please sign)

Date: ___/___/___

_____

Name of Client (please print)

_____

(please sign)

Date: ___/___/___

_____

Name of Client (please print)

_____

(please sign)

Date: ___/___/___

Rosewood
Mental Health Services

FEES
Effective 1 January 2014

Consultation

Initial Consultation (30 minutes)…… No Charge
Subsequent Consultations (50 minutes)..…… €25

Counseling

Family Counseling
Initial Assessment Session (90 minutes) …… €60
Subsequent Sessions (50 minutes) …… €40
Couples Counseling
Initial Assessment Session (90 minutes) …… €60
Subsequent Sessions (50 minutes) …… €40
Individual Counseling
Initial Assessment Session (90 minutes) …… €50
Subsequent Sessions (50 minutes) …… €30

Therapy

EMDR (Trauma)
Initial Assessment Session (90 minutes) ……..…. €120
Subsequent Sessions (90 minutes) …… €120

CBT
Initial Assessment Session [Family] (90 minutes) …… €100
Subsequent Sessions (50 minutes) …… €65
Initial Assessment Session [Couples] (90 minutes) …….. €90
Subsequent Sessions (50 minutes) …… €60
Initial Assessment Session [Individual] (90 minutes) …… €85
Subsequent Sessions (50 minutes) …… €55

RAD & Developmental Trauma Disorder
Sessions (120 minutes)..…… €200