

A COUNSELOR FOR SOUL SEARCHERS

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New Client Form

Please fill out this form as completely as possible and bring to your first session.

Your information will be kept strictly confidential and used only for internal or insurance purposes.

**Please write as clearly as possible.**

**Basic Information:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_ Single \_\_\_Married \_\_\_\_Remarried \_\_\_ Divorced \_\_\_ Separated

\_\_\_ Widowed \_\_\_ Engaged \_\_\_ In a Relationship

If applicable:

Partner/Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Partner/Spouses Birth date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

Reason(s) for seeking counseling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Details of Patient/Therapist Agreement:**

Please read the following important information for clients of The Relationship Center of St. Louis. Your signature at the end of this form signifies that you have read and understand the following:

**1. Confidentiality Agreement**

Your personal information, as well as everything discussed during individual and group therapy sessions is held in strict confidentiality. If, for any reason, we want to share your information with anyone, including other clinicians, therapists, medical professionals, or any other individual or agency, we will obtain written permission.

**Limits to Confidentiality**

We may be required to report certain conditions to the proper authorities, including situations in which we believe that your life is in imminent danger (for example, if we believe you to be suicidal). We are also required to report situations in which children or elderly persons are being or may be physically abused. We agree to inform you of our obligation to report dangerous situations before making such report. The mutual confidentiality arrangement for couples counseling will need to be discussed and clarified.

**2. Therapist and Client Responsibilities**

In entering into a therapist-client relationship, it is best for both parties to agree to certain responsibilities in order to maximize the effectiveness of the therapy process.

**Client Responsibilities**:

As a client, it is best if you agree to be honest, willing to change, open to feedback and suggestions, and willing to be patient with yourself and the growth process. It also works best if you also agree to take responsibility for, and an active role in, your growth and healing. Please agree to provide feedback on the therapist-client relationship and specify what you like and dislike about the process in general. In this way, you will improve the quality of your sessions and the potential for positive results.

**Therapist Responsibilities**:

As your counselor, I am guided by the core principles that you possess within yourself what you need to heal and overcome. My role is to activate your innate potential by actively listening, offering feedback and informed guidance, as well as teaching and inspiring where appropriate. To the best of my ability, my goal is to help you achieve your desired results. If any aspect of your therapy is not to your satisfaction, I agree to attempt to tailor the therapy process more specifically to your preferences, or to provide a referral for another therapist that may be able to more closely match your style and goals. I agree to offer treatment options that are consistent with the Missouri Code of Ethics.

**3. No Guarantee of Results**

In getting to know you and learning about your specific challenges, I will use my training and experience to guide you, help to increase your awareness and make educated suggestions on how you might achieve greater happiness and inner peace. Although I will make every effort to help you meet your treatment goals, I cannot guarantee results.

**4. Release of Liability**

I will make an effort to be available to you for regular and emergency consultations; however, I am not responsible for your actions inside or outside of therapy.

**5. Payment and Cancellation Policy**

Payment is due immediately following each session. I accept cash, personal checks or you pay online via paypal (paypal payments must be prior to the session). **I require 48 hours’ notice for cancellation of appointments**. Without at least 48 hours’ notice, you will be charged the entire fee for the missed appointment. Payment for a missed appointment is due on your next visit, or if you do not plan on making another visit, payment is due right away.

**6. Termination of Relationship**

Except in a court-ordered situation, therapy is strictly voluntary. Should you decide that you wish to end the therapist-client relationship, we ask that you inform me before your final intended appointment. This gives us an opportunity to maximize your next step and take advantage of what could be a missed opportunity for growth.

**7. Length of Sessions**

Sessions are 50 minutes. Longer sessions can be arranged for special circumstances. Sessions will begin wrapping up at least 5 minutes prior to the end to allow for a summary and clarification; and for payment/future appointments to be arranged.

**I certify that I have read, understand, and agree to this patient-therapist agreement.**

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_