COUNSELOR-CLIENT AGREEMENT

Please read and initial each section below indicating your understanding and agreement to the following terms and conditions:

Description of Counseling *Initials:* _____

Counseling is a unique relationship between therapist and client that endeavors to help a client grow. That growth may be emotional, relational, spiritual, practical, or, often, all of the above. Our counseling approach uses a variety of therapeutic models and techniques, including Existential Psychotherapy, Internal Family Systems Therapy, Cognitive Behavioral Therapy, Gestalt Therapy, Emotionally Focused Couples Therapy, and mindfulness techniques. We do our best to modify our counseling approach to fit the specific needs of each client because every person is unique. We also seek to be sensitive to religious and cultural differences.

In the course of psychotherapy/counseling there are benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems and significant long-term reductions in feelings of distress. Therapy calls for an active effort on your part, and in order to be most successful you will want to work on items we talk about both during our sessions and at home. Please remember that there is no guarantee of what you, personally, will experience.

We use the framework of the American Counseling Association's Code of Ethics to guide our practice. To refer to the ACA Code of Ethics, go to www.aca.org.

Confidentiality *Initials:* _____

We will maintain confidentiality in the counseling relationship. This means that your counselor and the other staff members of Imago Counseling will not share information about you or your counseling with others without your permission. However, there are specific situations in which we will break the normal bounds of therapeutic confidentiality. Those situations include the following:

1. When we assess that there is a serious threat to your or somebody else's physical safety.
2. When we learn that a child or vulnerable adult is being abused or neglected.
3. When legal requirements demand disclosure.

While other staff members and professionals at Imago Counseling may encounter information about you or your treatment, they are held to the same standard of privacy as your counselor. However, in group and couples counseling, we or any other co-therapists involved cannot be held responsible for a breach of confidentiality on the part of a peer group member.

If we encounter you socially outside of the counseling context we may ignore you or pretend that we don't know you. This is an effort to protect your confidentiality. We do not assume that you want to associate with us outside the therapy room. However, you are welcome to approach us and introduce us to others if you wish. Please feel free to talk to us in a social setting even if we do not approach you.

Referral Policy/Disclaimer *Initials:* _____

We will be clear with you regarding the scope of our practice. Should you require care that falls outside of that scope, we will, to the best of our ability, provide you with a referral to another professional or facility that offers that service. It is your full right to accept or deny this referral, but we will not be held liable for any services provided or not provided by that person or facility. If you choose to continue working with us after receiving a referral, we will not be held liable for the limitations of the services we offer which prompted said referral or any outcomes related to or caused by those limitations.

Scheduling *Initials:* _____

Counseling sessions are generally offered on a weekly basis for 60 minutes. It is our policy to schedule you for a standing appointment at the same time every week. If you feel like you would benefit from another arrangement, please discuss this with your counselor. We will do our best to accommodate your scheduling needs but cannot guarantee that we will be available at a time that is convenient for you.

Please reschedule or cancel your appointment at least 24 hours before your scheduled time.

Please note the following scheduling policies:
1. If you cancel between 2 and 24 hours before your scheduled appointment time you will be charged for half of the session fee. Cancelation less than 2 hours before the session or failure to appear for the appointment will result in a full charge for that counseling hour.
2. If you are unable to make your appointment time, you may request to reschedule at least two hours before the start of the session, but your counselor cannot guarantee availability at another time.

Payment *Initials:* _____

Our rate is 1,600 HKD per one hour session. Payment is collected after each meeting. We have various methods of payment for multiple currencies. Please refer to our website at imagocounseling.org/payment for more information.

We can provide a fee reduction on a limited basis in response to financial need. If you would like to inquire about fee reduction, ask your counselor for an application or download one from our website at imagocounseling.org/faq.

I have read, understand, and agree to the above terms and conditions.

Client printed name: _____

Client signature: _____ Date: _____

If the client is under 18 years of age:

Parent/Guardian 1 printed name: _____ Date: _____

Parent/Guardian 1 signature: _____ Date: _____

Parent/Guardian 2 printed name: _____ Date: _____

Parent/Guardian 2 signature: _____ Date: _____

INFORMED CONSENT TO CHILD PSYCHOTHERAPY

This form documents that we,

_____, _____
(the “parents”) give our consent and agreement to

_____
(the “psychotherapist") to provide psychotherapeutic treatment to our child,

_____
(the "child") and to include us, the parents, as necessary, as adjuncts in the child's treatment.

While the parents can expect benefits from this treatment for the child, they fully understand that no particular outcome can be guaranteed. The parents understand that they are free to discontinue treatment of the child at any time but that it would be best to discuss with the psychotherapist any plans to end therapy before doing so.

The parents have fully discussed with the psychotherapist what is involved in psychotherapy and understand and agree to the policies about scheduling, fees and missed appointments. The discussion about therapy has included the psychotherapist's evaluation of the child's problems, the method of treatment, goals and length of treatment, and information about record-keeping. The parents have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. The parents understand that therapy can sometimes cause upsetting feelings to emerge, and that the child's problems may worsen temporarily before improving.

The parents understand that the psychotherapist cannot provide emergency service. The psychotherapist has told the parents whom to call if an emergency arises and the psychotherapist is unavailable.

The parents understand that information about psychotherapy is almost always kept confidential by the psychotherapist and not revealed to others besides the parents unless a parent authorizes such release. There are a few exceptions. Details about certain of those exceptions follow:

1. The psychotherapist is required by law to report suspected child abuse or neglect to the proper authorities.

2. If a child tells the psychotherapist that he or she intends to harm another person, the psychotherapist must try to protect the endangered person, including by telling the police, the person and other health care providers. Similarly, if a child threatens to harm him or herself, or a child's life or health is in any immediate danger, the psychotherapist will try to protect the child, including, as necessary, by telling the police and other health care providers, who may be able to assist in protecting the child.

3. If a child is involved in certain court proceedings the psychotherapist may be required by law to reveal information about the child's treatment. These situations include child custody disputes, cases where a patient's psychological condition is an issue, lawsuits or formal complaints against the psychotherapist, civil commitment hearings, and court-ordered treatment.

4. The psychotherapist may consult with other healthcare professionals about the child's treatment, but in doing so will not reveal the child's name or other information that would identify the child unless specific consent to do so is obtained from a parent.

In all of the situations described above, the psychotherapist will try to discuss the situation with a parent before any confidential information is revealed, and will reveal only the least amount of information that is necessary. The parents agree that in the event custody of, or visitation with, the child is contested in a legal proceeding, each of the parents and their attorneys will not require the psychotherapist to testify at any of the proceedings, because to do so would hurt the child's treatment, because the psychotherapist's role is a therapeutic and not evaluative one, and because other forensic professionals would be better able and more appropriate to conduct any necessary evaluation. Because of these limitations, the psychotherapist also will not be able to give any opinion regarding custody, visitation or any other legal issue. If such a proceeding does occur, the parents agree that the psychotherapist's role will be limited to providing to a mental health professional appointed to perform such an evaluation, and/or to the attorneys, law guardian, if any, and the judge involved in the legal proceeding, written information regarding, and/or the record of, the child's treatment; the psychotherapist will provide these either as required by law or upon the authorization of either parent.

The psychotherapist has explained to the parents that children with two parents have the best chance to benefit from therapy if both parents are involved and cooperate with each other and the psychotherapist. If both of a child's parents are consenting to therapy:

■ Each of us agrees that he or she will not end the child's therapy without the agreement of the other parent, and that if we disagree about the child's continuing in therapy, we will try to come to an agreement, by counseling if necessary, before ending the child's therapy.

■ We each agree to cooperate with the treatment plan of the psychotherapist for the child and understand that without mutual cooperation, the psychotherapist may not be able to act in the child's best interests and may have to end therapy.

■ We agree that each of us has and shall continue to have the right to information about the child's treatment and to the treatment records of the psychotherapist regarding the child, and agree that the psychotherapist may release information or records to either of us without any additional authorization of the other.

The parents, as legal guardians of the child, have rights to general information about what takes place in the child's therapy, to information about the child's progress in therapy, to information about any dangers the child might present to self or others, and, upon request, to obtain copies of the child's treatment record (with certain qualifications and exceptions). ***The parents understand that it is usually best not to ask for specific information about what was said in therapy sessions because this might break the trust between the child and the psychotherapist, especially for children over the age of 12.***

By signing below the parents are indicating that they have read and understood this agreement, that they give consent to the psychotherapist's treatment of the child, and that they have the proper legal status to give consent to therapy for the child.

Parent/Guardian 1 printed name: _____ Date: _____

Parent/Guardian 1 signature: _____ Date: _____

Parent/Guardian 2 printed name: _____ Date: _____

Parent/Guardian 2 Signature: _____ Date: _____

Child Signature: _____ Date: _____
(if over 12 years of age)

CONFIDENTIAL INTAKE FORM

Date: _____ Referred by: _____

GENERAL INFORMATION

Full name: _____ ☐ Male ☐ Female

Other name/Name you prefer: _____ Age: _____

Date of birth: _____ Country of birth: _____

Address: _____

_____

Other address (if applicable): _____

_____

Mobile phone: _____ May we call you here? ☐ Yes ☐ No

May we leave messages here? ☐ Yes ☐ No May we text you here? ☐ Yes ☐ No

Other phone (if applicable): _____ May we call you here? ☐ Yes ☐ No

May we leave messages here? ☐ Yes ☐ No May we text you here? ☐ Yes ☐ No

Email address: _____ May we contact you here? ☐ Yes ☐ No

Other preferred contact method (WhatsApp, Signal, etc.): _____

Employer: _____

How long have you worked there/been unemployed? _____

Occupation/Job title: _____

Are you currently in school? ☐ Yes ☐ No If yes, where? _____

Degree, certificate, or skill pursuing: _____

RELATIONAL INFORMATION

Emergency contacts: *Please provide at least one emergency contact in the city where you spend most of your time. If you live or work in other places, please include a contact in your city of residence and in each city where you are likely to spend more than 4 weeks of your time over the next year. These contacts should be people you trust, and can include family, friends, work partners, or mentors.*

Name: _____ Relationship: _____

Phone number(s): _____

Email or other method of contact: _____

Name: _____ Relationship: _____

Phone number(s): _____

Email or other method of contact: _____

Family Information:

Marital status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If dating, engaged, married, separated, divorced, or widowed, for how long? _____

Number of previous marriages for you: _____ For your partner or spouse: _____

With whom do you currently live? (*Check all that apply.)* ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s)

☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _____

List all family members who had a significant effect (positive or negative) on your life, such as your partner/spouse, mother, father, brothers, sisters, and step-family relations.
(Use the space at the end of the document if you run out of room)

Name	Sex	Current age or year of death if deceased	Relationship to you

List your children (including step, adopted, and foster children) below:
(Use the space at the end of the document if you run out of room)

Name	Sex	Current age or year of death if deceased	Who is he/she living with?

Have you ever placed a child for adoption? ☐ Yes ☐ No

If Yes, when? _____

Have you or your partner ever had a miscarriage or an abortion? ☐ Yes ☐ No

If Yes, when? _____

MEDICAL HISTORY

How would you rate your current physical health?

☐ Very poor ☐ Poor ☐ Adequate ☐ Good ☐ Very Good

How has your weight changed in the last 2-3 months? ☐ Little to no change ☐ Increased ☐ Decreased

If it has increased or decreased, by how much? _____

Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

Have you experienced any medical conditions, accidents, or surgeries in the past that had a significant impact on your life? If so, please describe: _____

_____

_____

_____

_____

Please list all current medications and supplements you are taking, including those you seldom use or take only as needed: *(Use the space at the end of the document if you run out of room)*

Name of medication	Dose and frequency	Reason for taking medication

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/inpatient care, please list the names of the therapists or programs:
(Use the space at the end of the document if you run out of room)

Therapist's name or program	Issues addressed/reason for seeking help	Dates

PRESENT ISSUES

Please check all that apply to you:

"Present" means within the last 6 months

Past	Present		Past	Present		Past	Present	
☐	☐	Stress	☐	☐	Major life transition	☐	☐	Financial problems
☐	☐	Anxiety, worry, or fear	☐	☐	Indecisiveness	☐	☐	Pornography use
☐	☐	Panic	☐	☐	Problems with friends or coworkers	☐	☐	Sexual problems
☐	☐	Feeling worthless or inferior	☐	☐	Loneliness	☐	☐	Gender identity or sexual identity issues
☐	☐	Depression	☐	☐	Crying all the time	☐	☐	Poor concentration
☐	☐	Feeling hopeless	☐	☐	Feelings of guilt	☐	☐	Lack of motivation
☐	☐	Fatigue/Lack of energy	☐	☐	Spiritual apathy	☐	☐	Obsessive thoughts
☐	☐	Trouble sleeping	☐	☐	Bad dreams	☐	☐	Unwanted memories
☐	☐	Issues with work, school, or team	☐	☐	Eating problems	☐	☐	Excessive drug or alcohol use
☐	☐	Couple relationship problems	☐	☐	Parenting problems	☐	☐	Experience of physical abuse
☐	☐	Death of a friend or loved one	☐	☐	Major loss	☐	☐	Experience of sexual abuse
☐	☐	Feelings of anger	☐	☐	Aggressive behavior	☐	☐	Experience of other abuse: _____
☐	☐	Chronic pain or health concerns	☐	☐	Seeing or hearing things others don't see or hear	☐	☐	Other: _____

Please circle any topics on the above list that you particularly want to discuss with your counselor.

Please place an "X" on the line below to indicate how distressing these problems are for you:

Minimally distressing Moderately distressing Extremely distressing

Have you ever thought about killing yourself? ☐ Yes ☐ No

If yes, when did you most recently have those thoughts? _____

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, when and how? _____

Are you currently experiencing any thoughts of harming another person? ☐ Yes ☐ No

Family history:

Have any of your friends or family ever attempted or completed suicide? ☐ Yes ☐ No

If yes, who, when, and how? _____

Has anybody in your family had a substance abuse problem or a mental illness? ☐ Yes ☐ No

If yes, who, and what problem or illness? _____

What do you hope to gain or change by coming for counseling at this time?

_____

_____

_____

_____

_____

_____

_____

Is there anything else that you want us to know? Did you run out of room on an earlier question?

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____