The Relationship Center of St. Louis

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New Client Form

Please fill out this form as completely as possible and bring it to your first session.
If you plan to fax us your forms, please call first. Your information will be kept strictly confidential and will be used only for internal and insurance purposes.
Please write as clearly as possible.

Basic Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____

Birth Date: _____/ ____/_____

Marital Status: __Single __Married __Remarried __Divorced __Separated __Widowed __Engaged

If married, length of marriage: _____ Is this your first marriage? __Yes __No

Referred by: _____

Which therapist will you be visiting? (leave blank if not sure)

__ Bill Wing __ Linda Wing __ Kathy Bearman
__ Wm. Grant Ellis __ Sharon Olson Gilmore __ Pam Weber

Medical Information (please note, we will not contact your doctor(s) without your permission)

Reason(s) for seeking therapy: _____
_____

Are you currently receiving medical care for mental health concerns? __Yes __No

If yes, what is the reason for the medical treatment? _____

Name of doctor: _____

Have you been hospitalized? __Yes __No

If yes, please explain briefly below: _____
_____

Family Information

Who else lives in your household? _____
_____

Ages/Genders of Children (Please specify stepchildren): (**example: 13/girl, 6/boy**)
Your Children: _____
Stepchildren/Spouse's Children: _____

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.

2. **Therapist and Client Responsibilities**

In entering into a therapist-client relationship, both parties must agree to certain responsibilities in order to maximize the effectiveness of your treatments.

Client Responsibilities:

As our client, you agree to be honest and open to suggestions. You also agree to take an active role in your treatment. You agree to provide feedback on the therapist-client relationship and specify what you

like and dislike about your treatment and about the process in general. In this way, you will improve the quality of your sessions by allowing us to tailor our style more to your preferences.

Therapist Responsibilities:

Although each therapist in our office has his/her own treatment style and psychological training background, we are all guided by the same core principles. Your therapist agrees to be an active listener and to offer informed advice to the best of his/her ability, with the goal of helping you to achieve your desired results. If any aspect of your therapy is not to your satisfaction, your therapist agrees to attempt to tailor your treatment more specifically to your preferences, or to provide a referral for another therapist that may be able to more closely match your treatment goals. We 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 situation, we will use our training and experience to make educated suggestions on how you might achieve greater happiness and self-satisfaction. Although we will make every effort to help you meet your treatment goals, we cannot guarantee results.

4. **Release of Liability**

Your therapist will make an effort to be available to you for regular and emergency consultations, however, we are not responsible for your actions inside or outside of therapy.

5. **Payment and Cancellation Policy**

Payment is due immediately following each session. We accept cash, personal checks, and credit cards.

We require 24 hours' notice by phone for cancellation of appointments. Without the proper notice, you will be charged the entire fee for the missed appointment. Please do not cancel appointments by e-mail. Our phone system accepts messages 24 hours a day and we check our messages several times daily. Payment for a missed appointment is due on your next visit, or if you do not plan on making another visit, payment is due immediately.

6. **Termination of Relationship**

Except in a court-ordered situation, therapy is strictly voluntary. Should you decide that you wish to terminate the therapist-client relationship, we ask that you inform your therapist before your final intended appointment. This gives your therapist an opportunity to help equip you to further your emotional progress outside of therapy.

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

Client Signature: _____ Date: _____

Printed Name: _____