Justin Stum Consulting Inc.
168 N. 100 E. #201
St. George, UT 84770

Office Policies and Informed Consent

Agreement to Counseling

Justin Stum Consulting Inc.

CONFIDENTIALITY

Confidentiality: All information disclosed within therapy sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property or is gravely disabled or when client's family members communicate to their assigned therapist, that the client presents a danger to others.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist.

Couples and Family Therapy: In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Your assigned therapist will use his clinical judgment when revealing such information an only do so based upon his clinical judgment as to what is best for the couple or family.

Initial __________

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on Justin Stum Consulting Inc or Justin Stum, MS, LMFT to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

Initial __________

Mediation & Arbitration: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Justin Stum Consulting Inc and the therapist you are working with and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in Washington County, UT in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Justin Stum Consulting Inc can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

Initial _________

Discussion of Treatment: Within a reasonable period after the initiation of treatment, your therapist will discuss with you (client) his working understanding of the problem, treatment, therapeutic objectives and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, your therapist's expertise in employing them or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that therapists at Justin Stum Consulting Inc. does not provide, he has an ethical obligation to assist you in obtaining those treatments.

Payments: The session fee is $150. This is for a traditional 50-minute session unless other arrangements have been made and is to be paid at the conclusion of the session if you did not prepay for the appointment. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments. If your account is overdue (unpaid) and there is no written agreement on a payment plan, Justin Stum Consulting Inc can use legal or other means (courts, collection agencies, etc.) to obtain payment.

Insurance: Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company. Not all issues/conditions/problems dealt with in psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If you would like to use your insurance company I can provide you with documentation of your sessions and you would need to then submit that information and they can reimburse you. Your being reimbursed is between you and your insurance provider directly; I do not guarantee reimbursement as that is up to your insurance company and the plan specifics you have with your individual plan.

Billing and Payment: Payment is collected at the time of each appointment. Each session is $150 and payment is due at the session time by cash, check, credit card, or HSA card. Checks should be made to "Justin Stum".

Cancellations: All clients must have a credit card on file. Since the scheduling of an appointment involves you reserving a time slot on my calendar specifically for you, a minimum of 24 hour's notice is required for re-scheduling or canceling an appointment and not incur a charge on your account. If you forget or otherwise miss your appointment, the full session cost will be charged for the missed session without such notification by phone or text to Justin Stum, LMFT. I'm happy to amend the schedule and change things but need to be contacted by you according to the terms above.

Card Number ________________________________

Expiration _______

CVV Code _______

Zip Code ______________

Initial _______

I have read the above Agreement, Informed Consent, Office Policies and General Information carefully.

By signing below you agree you understand to comply with them:

_______________________ _______________ ___________________________

Client Name (print) Date Signature

_______________________ _______________ ___________________________

Client Name (print) Date Signature

Justin Stum, MS, LMFT _______________ ___________________________

Therapist Date Signature

Client Information

Please fill out the information below. The information will help me understand better who you are and what you are seeking from counseling. Please fill out this form as completely as possible. If you have any questions, please feel free to ask.

SECTION I: IDENTIFYING INFORMATION Today's Date: _______________

Name__________________________________ Age___ Date of Birth_________ Gender __M, __F

Address_______________________________________ City__________________ Zip__________

Home Phone_______________ Cell Phone_____________ Is it OK to leave a message at home? __Yes, __No

Occupation_________________________ Work Phone_______________ Contact at work? __Yes, __No

E-mail (optional)____________________________ Is it OK to contact you by email? __Yes, __No

Marital Status: ___Single, ___Married, ___Co-habiting, ___Separated, ___Divorced, ___Widowed

Religious Affiliation _____________________

Name of Spouse/Partner_________________________________ Age___ Date of Birth_________

Children: Name: _______________ Age: __ Lives with you? __Yes, __No

Name: _______________ Age: __ Lives with you? __Yes, __No

Name: _______________ Age: __ Lives with you? __Yes, __No

Name: _______________ Age: __ Lives with you? __Yes, __No

Name: _______________ Age: __ Lives with you? __Yes, __No

Name: _______________ Age: __ Lives with you? __Yes, __No

Among your friends and family, whom do you count on for support?

____

In case of an emergency: Emergency contact person ______________________________
Phone______________________ Relationship to you ___________________________________

Referred to Justin Stum by: ____

Section II: PREVIOUS COUNSELING AND MEDICAL HISTORY

Have you ever had treatment by a psychiatrist, psychologist, or counselor in the past? ____ Yes, ____No
If yes, please describe the reasons for treatment.

____
____
____

Please list any current or previous health problems.

____
____
____

Please list any medications that you are currently taking (including daily dosage).

____
____

What substances do you regularly use? ___Alcohol, ___Tobacco, ___Marijuana, ___Meth, ___Cocaine ____Vape

SECTION III: DESCRIPTION OF PRESENTING PROBLEM

Please describe your primary reasons for seeking counseling/therapy.

____
____
____
____

How long has this been a concern/problem for you?

____
____

Have there been any events that are associated with this problem (traumatic event, relationship ending, etc.): ____
____
____

In the past, what has been helpful to you in dealing with this problem?

____
____

Are you currently suffering from any of the following? Please check **all** that apply:

__overeating __restless __rapid heart rate __compulsive behaviors
__taking drugs __depressed mood __sweating __fears/phobias
__crying __trembling/shaking __anxiety __recent weight loss
__shortness of breath __excessive drinking __low motivation __recent weight gain
__muscle tension __distrust __social withdrawal __difficulty concentrating
__aggressive behavior __outbursts of temper __nervous __sexual dysfunction
__nightmares __dizzy or lightheaded __chest pain __feelings of worthlessness
__stomach problems __easily distracted __fatigue/loss of energy __can't fall asleep
__sleeping too much __obsessions __erectile dysfunction __decreased need for sleep
__poor self-esteem __family problems __financial problems __abusive home situation
__problems with school __housing problems __marital problems __pain
__death of a loved one __childhood trauma __problems at work __other traumatic events

other(s):____

Please describe any other information that you feel is important for the therapist to know.