

ADULT/ COUPLE INTAKE FORM

(Please Print)

Date: / /		How did you hear about us?			
<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	Full Name (<i>Last</i>)	(First)	(Middle)	
<input type="checkbox"/> Ms.	<input type="checkbox"/> Miss.				
<input type="checkbox"/> Dr.	<input type="checkbox"/> Rev.				
Nick Name:		Name You Prefer:		Birth date:	Age:
				/ /	<input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian/Power of Attorney: (if applicable)		Social Security#		Race:	
		- -		<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Other: _____ <input type="checkbox"/> Hispanic	
CONTACT INFORMATION					
Street address:			Suite/Apartment Number:		
City:	State:	ZIP Code:	May We Send Mail Here: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mailing Address or Post Office Box:					
City:	State:	ZIP Code:	May We Send Mail Here: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Home Phone:	()	May We Leave a Message Here:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mobile Phone:	()	May We Leave a Message Here:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Phone:	()	May We Leave a Message Here:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Email Address:			May We Send Email Here: <input type="checkbox"/> Yes <input type="checkbox"/> No		
EMERGENCY CONTACT					
Name:			Relationship:		
Home Phone: ()			Mobile Phone: ()		
EMPLOYMENT INFORMATION					
Employer:			Length of Employment:		
Occupation:			Average Hours Worked Per Week:		
Average Annual Salary: <input type="checkbox"/> \$0 to \$10,000 <input type="checkbox"/> \$10,001 to \$20,000 <input type="checkbox"/> \$20,001 to \$40,000 <input type="checkbox"/> \$40,001 to \$50,000					
<input type="checkbox"/> \$50,001 to \$60,000 <input type="checkbox"/> \$60,001 to \$80,000 <input type="checkbox"/> \$80,001 to \$100,000 <input type="checkbox"/> More than \$100,000					
EDUCATION INFORMATION					
(Circle) Last Year of School Completed: 9 10 11 12 GED			College: 1 2 3 4	Other: _____	
Are You Currently in School? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, What School:			
RELATIONAL INFORMATION					
Current Status:			Are You Content with Your Current Status? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Single <input type="checkbox"/> Dating <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living together			If No, Briefly Explain:		
If Married, How Long: _____		Number of Previous Marriages for You: _____		For Your Partner: _____	
If Separated or Divorced, How Long: _____		If Widowed, How Long: _____			

Partner's Name (Last, First, Middle): _____	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.
	<input type="checkbox"/> Ms.	<input type="checkbox"/> Dr.
	<input type="checkbox"/> Miss.	<input type="checkbox"/> Rev.

How long Have You Known Your Partner: _____	Age: _____	Preferred Name: _____
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Partner's Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Other: _____ <input type="checkbox"/> Hispanic	Partner's Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Partner's Occupation: _____ Average Hours Worked Per Week: _____
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(Circle) Last Year of School Partner Completed: 9 10 11 12 GED	College: 1 2 3 4	Other: _____
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What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Partner Doesn't Know Who will be attending therapy with you? _____ _____	With Whom Do You Currently Live (Check All that Apply): <input type="checkbox"/> Alone <input type="checkbox"/> Boyfriend <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Girlfriend <input type="checkbox"/> Roommate <input type="checkbox"/> Parent(s) <input type="checkbox"/> Sibling(s) <input type="checkbox"/> Other: _____
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CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You <i>Natural, Adopted, Step</i>	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: Yes No If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: Yes No If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, & Any Other Family Members who Affected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You <i>(Mom, Dad, Sibling, Step)</i>	Occupation	Describe Him/Her

PRIMARY PHYSICIAN INFORMATION

Primary Physician: _____ Phone: () _____
Address: _____ City: _____ Zip: _____
Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): _____
Are You Currently Receiving Medical Treatment: Yes No If Yes, Please Specify: _____
List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had (Use Back if Necessary): _____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):
Medication: _____ Dosage: _____ Improves Prevents Controls: _____
Medication: _____ Dosage: _____ Improves Prevents Controls: _____
Are You Taking these Medication(s) According to Your Doctor's Recommendations: Yes No
If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:
Headaches----- Past Present Dizziness Past Present Stomach Trouble Past Present
Visual Trouble----- Past Present Sleep Trouble Past Present Trouble Relaxing Past Present
Weakness ----- Past Present Tension Past Present Rapid Heart Rate..... Past Present Difficulty
Breathing----- Past Present Intestinal Trouble Past Present Hearing Noises Past Present Change in
Appetite ----- Past Present Tiredness..... Past Present Pain Past Present
Hearing Voices----- Past Present Seeing Things..... Past Present Other Past Present Your
Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You:
Stress Past Present Nervousness Past Present Anxiety Past Present
Panic Past Present Unhappiness Past Present Depression Past Present
Guilt..... Past Present Apathy Past Present Terminal Illness Past Present
Recent Death Past Present Grief Past Present Hopelessness Past Present Inferiority
Feelings Past Present Defective Feelings Past Present Loneliness Past Present Shyness
..... Past Present Fears Past Present Friends Past Present Marriage
..... Past Present Communication..... Past Present Physical Abuse..... Past Present
Emotional Abuse Past Present Verbal Abuse..... Past Present Sexual Abuse Past Present
Temper..... Past Present Anger..... Past Present Aggressiveness Past Present Bad
Dreams Past Present Concentration Past Present Racing Thoughts Past Present
Unwanted Thoughts Past Present Memory Past Present Loss of Control Past Present
Impulsive Behavior Past Present Self-Control Past Present Compulsivity Past Present
Sexual Problems Past Present Pregnancy Past Present Abortion..... Past Present
Legal Matters..... Past Present Trauma..... Past Present Eating Problems Past Present
Drug Use Past Present Alcohol Use Past Present Trouble with Job Past Present
Career Choices Past Present Ambition Past Present Making Decisions Past Present
Children..... Past Present Being a Parent..... Past Present Finances..... Past Present
Recent Loss Past Present Disaster Past Present Smoke Cigarettes Past Present
Self-Harm Past Present Hi Risk Behavior Past Present Zoning/blanking out Past Present

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below (1 = Very Little Distress; 10 = Extreme Distress):
1 2 3 4 5 6 7 8 9 10
Are You Currently Having Any Suicidal Thoughts? Yes No Have You Having Them in the Past? Yes No
Have You Ever Attempted Suicide: Yes No If Yes, When and How: _____
Have Any of Your Friends or Family Ever Committed or Attempted Suicide: Yes No
If Yes, When and Who: _____

Alicia D. Hart, MMFT, M. Div., EdS., LMFT | 101 North Pine Street, Suite 210, Spartanburg, SC 29302

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Therapy (i.e. What Are Your Issues, Problems?): _____

Why Have You Decided to Come for Therapy Now: _____

What Do You Hope to Gain or Change by Coming for Therapy: _____

How Long Do You Believe Therapy Should Last: _____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (*Use Back If Necessary*):

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

RELIGIOUS BACKGROUND

Please describe your religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of?

Church attendance? If so, what is the name? _____

Would you like spiritual principles incorporated into your therapy? Yes No

TERMS OF SERVICE

I hereby give Alicia D. Hart, therapist permission to provide therapy services for the patient mentioned above:

Signed: _____ Date: _____

FINANCIAL POLICY

Payment Policy: We are committed to providing you with the best possible care. **Payment for services is due at the time of service.**

- Initial assessment for 90 minutes – 2 Hours: \$160.00-\$240.00
- One 50 - 60 minute session: \$100 /Hour (cash amount). See insurance policy below.
- Families are \$_____per session: case by case basis
- Additional Services: Treatment Summary/Narrative Reports, affidavits, Professional Letters, Emails, Phone/Conference calls will be billed in 15 minute increments @ \$25 per 15 minutes of billable services.
- Administrative Services: Letters, insurance forms, authorization requests will be billed @ \$25 each request.
- If your case is a court case, you MUST pay a deposit. This deposit is in the amount of \$500.00 and is refundable if not used towards billable work. If I receive a subpoena for court, see below. There will be additional fees for court preparation, writing reports, writing affidavits, etc.
- Subpoena, Court Appearances, and Depositions are billed at \$800 for up to 6 hours. NOTE: If therapist receives a subpoena for court, this fee will be paid to therapist unless cancelled two weeks in advance and must be in writing from an attorney. Your deposit can go towards this fee.
- Returned checks are subject to a \$35 fee.
- No-show fees are charged for appointments canceled or broken without 24 hours advance notice unless there is an emergency or illness. Monday appointments must be canceled by the Friday in advance at Monday appointment time or before. **The no-show fee is \$100. When leaving a message, all calls are time and date stamped.**

Policy on Insurance Reimbursement:

If you have medical Insurance that provides coverage for mental health counseling, we are anxious to help you receive your maximum allowable benefits.

We will be happy to provide you with a receipt to forward to your insurance company. You are responsible for generating the claim and mailing it to the insurance company and tracking your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract unless we are a provider to that specific insurance company. We are providers for the following insurance: Medicaid First Choice/Select Health, Wellcare Medicaid, Healthy Blue Medicaid, Blue Cross Blue Shield (BCBS). We file insurance for insurance that is out of network; however, you are required to pay for the session out of pocket. Most insurance companies do not reimburse to out of network providers. We may also provide a complimentary Super Bill if requested by your insurance company.
2. Our fees are considered to fall within the acceptable range by most companies, called "Usual, Customary and Reasonable" (UCR). Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your company requests a report from us in order to process your claim, we will need to receive our normal hourly fee from you for this service.

Rate Policy:

- Each therapist regulates their own minimum rate. Appointments are scheduled directly with the therapist.
- Fees listed are for one clinical hour (50 - 60 minutes). Longer sessions are calculated by .5 hour increments
- Proof of income may be required. All financial information is kept confidential.
- Discounts for multiple clients or weekly sessions, from the same family, may be arranged on a case by case basis.

We understand that at times financial hardships arise and it may be necessary to discontinue therapy for a season. However, it is our policy to work within our client's financial means in order to support the therapeutic process. Should your fee for service become a financial hardship for you, please discuss this with your therapist. As is the policy of the State of South Carolina and included in the AAMFT code of ethics, Marriage and Family Therapists are prohibited from bartering for service.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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Section applicable only for reduced fees:

Amount agreed upon for initial assessment \$ _____

Clients Initials: _____

Amount agreed upon for therapy per 50 minute session \$ _____

Therapist Initials: _____

Time agreed upon for reduced fee _____

Date fee agreement revisited _____, Notes: _____

COURT CASES

- It is important that you understand Hart to Heart Therapy's policies on court cases. Below I have provided some facts for you to consider.
 - Court cases are more involved and require more time than regular cases.
 -

Informed Consent & Release of Liability

This form is to document that I, _____ give my permission and
PRINT NAME

Consent for treatment to _____ (clinician), to provide therapy for me
and/or who is/are my child/children or for whom I am legal guardian custodian, or legal Power of Attorney.

PRINT NAME(S) _____

I understand the following:

- This therapist is not providing an emergency service, and I have been informed of whom to call in an emergency or during weekend and evening hours.
- Conversations with the therapist will be almost always confidential. However, the therapist, by law, must report actual or suspected child, spouse, or elder abuse to the appropriate authorities. The therapist also has a legal responsibility to protect anyone I may threaten with violence, harmful, or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. The therapist will make reasonable efforts to resolve these situations before breaking confidentiality.
- I am financially responsible for this treatment.
- I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.
- I have read and received the Office Policies & General Information Agreement for Psychotherapy Services and I agree to the policies. I have also received a copy of the HIPAA Notice of Privacy Practices. I have discussed any concerns about the policies with the therapist prior to signing this consent.
- I understand that my case may be reviewed by state approved supervisors with my confidentiality to be held in highest regards.
- I understand that peer to peer supervision may be done on a case by case basis.

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- I understand that I am NOT allowed to audio or video tape sessions of other conversations with the therapist.
- I understand that the therapist has the right to video or audio tape a session to use for supervision and treatment plans. If in the event a tapped session discloses abuse, neglect, or any reportable behavior, the therapist has the legal right to forward the recording to the proper authorities.

Disclosure Statement

Your decision to enter into therapy was undoubtedly a serious one arrived at after considerable thought. Whether you were referred by your physician, urged to come by family or friends or have come because of problems and feelings only you know about, the decision to come here was yours.

Therapy is a two-way effort entailing mutual respect, responsibility and consideration between you and your therapist. The policy presented is designed to make your therapy productive and to avoid any misunderstanding regarding the mutuality of the therapeutic process.

As a Marriage and Family Therapist, my area of training is the systemic treatment of individuals, couples, and families. The systemic approach to therapy takes into consideration all immediate family members in family therapy sessions. I, along with you, will decide which family members (if any) need to be included in therapy. Various goals will be established together with you at the outset of therapy.

Therapy naturally involves activities such as identifying emotions and revealing secrets. There may be risks associated with our disclosures to other family members or other family members' disclosures during the course of therapy, as well as exploration of issues. Decisions to disclose will be made by you except where mandated by law. It is expected that some uneasiness or painful emotions may occur as you are involved in therapy. Discussing painful issues will naturally create discomfort. Your participation in therapy is essential toward helping address your concerns. The Board of Examiners for the Licensure of Professional Counselors, Marriage and Family Therapists and Psychoeducational Specialists requires that all clients be informed that all forms of dual relationships such as business ventures and sexual intimacy are prohibited.

Please be aware that there is a higher incidence of divorce if only one partner in a relationship is involved in therapy. It is also important that you understand there is no guarantee all of your concerns, issues, or problems will be successfully resolved. I cannot guarantee outcomes. The outcomes may vary from your expectations. You may discontinue participation in therapy at any time. If you are not satisfied with the course of the therapy, please discuss this concern with me.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

This Notice Describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIP AA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIP AA provides penalties for covered entities that misuse personal health information. As required by HIP AA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or

administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

- You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:
 - The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
 - The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
 - The right to request an amendment to your PROTECTED HEALTH INFORMATION.
 - The right to obtain a paper copy of this notice for us upon request. We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
South Carolina Labor, Licensing, and Regulation
www.llr.state.sc.us/pol/counselors/index.asp?file=CCE.htm

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C 20201
877.696.6775 (toll-free)

KEEP FOR YOUR RECORDS

Alicia D. Hart, MMFT, M.Div., EdS., LMFT 101 North Pine Street, Suite 210 |Spartanburg, SC 29302

ACKNOWLEDGEMENT OF RECEIPT PRIVACY PRACTICE NOTICE

I, _____ have received a copy of Alicia D. Hart, Therapist Notice of
(Print Full Name) Privacy Practices.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF EMERGENCY INFORMATION

I, _____ have received a copy of Alicia D. Hart, Therapist
(Print Full Name) Emergency Information.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

CLIENT E-MAIL or TEXT MESSAGING USAGE CONSENT

Your therapist will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks identified below, your therapist cannot guarantee the security of e-mail communication, and is not liable for improper disclosure of confidential information that is not caused by the therapist's intentional misuse.

RISKS OF USING E-MAIL/ TEXT TO COMMUNICATE WITH YOUR THERAPIST

Transmitting client information by e-mail has a number of risks that clients should consider before using e-mail to communicate with your therapist. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail can be received by unintended recipients.
- E-mail senders can easily type in the wrong email address.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies or e-mail may exist even after the sender/recipient has deleted their copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

CLIENT OBLIGATIONS WHEN CONSENTING TO E-MAIL/ TEXT

- Use e-mail for general client information only.
- Follow up with your therapist if you have not received a response to your email within 5 business days.
- Take precautions to preserve the confidentiality of e-mail. Use screen savers and safeguard your computer with a password. Change your password regularly.
- Inform your therapist of any changes to your e-mail address.
- Withdraw consent to email client information through hardcopy written communication to your therapist.

ALTERNATE FORMS OF COMMUNICATION

I understand that I may communicate with the therapist via telephone or during a scheduled appointment, however e-mail is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive information.

TYPES OF E-MAIL/ TEXT TRANSMISSIONS THAT CLIENT AGREES TO SEND AND/OR RECEIVE

The types of information that can be communicated via e-mail with your therapist includes: appointment scheduling requests, billing and insurance questions and client education. If you are not sure if the issue you wish to discuss should be included in an e-mail, you should schedule an appointment.

HOLD HARMLESS

I agree to indemnify and hold harmless Alicia D. Hart, Therapist, and any employee, website designer, and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the therapist or the use of the therapist's web-site, any arrangements you make based on information obtained by the Site, any products or services obtained through the Site, and any breach by me of these restrictions and conditions. The therapist does not warrant that the functions contained in any materials provided will be interrupted or error-free, that defects will be corrected, or that the therapist's website or server that makes such site available is free of viruses or other harmful components.

I also understand that all of the above information, notice and agreements apply for text messages sent to or from the therapist's office cell phone.

Client

Signature: _____

Date: _____

Emergency Information

We strive to return all calls in a timely manner. As we do not have a receptionist, the therapists at Alicia D. Hart, Therapist will be checking voicemail throughout the day. Our goal is to return your call within a 24 hour period. You will be contacted as soon as your therapist is able. If you have an emergency after office hours, please call 911 or go to the nearest emergency room.

Emergency Services:	911
Greenville Memorial Hospital Info Line:	(864) 455-7000
Greenville Mental Health Crisis Line: Greenville	(864) 241-1040
Rape Crisis and Child Abuse Greer Mental Health	(864) 467-3633
Shepherd's Gate Womens Shelter SAFE Homes	(864) 268-5589
Rape Crisis	(864) 583-9803
Suicide Prevention Hotline	(864) 271-8888
Spartanburg Regional Emergency Room	(864) 560-6222
Spartanburg Mental Health Crisis Line	(864) 585-0366
24-hour Child Abuse Line	(864) 585-1445
Carolina Center for Behavioral Health	(864)235-2335

KEEP FOR YOUR RECORDS

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