J. Selah Richards, MS LPC-S
Ph/Text: 469-855-7795 / Fax: 469-521-1077
1408 W Abram St #108, Arlington, Texas 76013
Selah@SelahCares.com
SelahCares.com

For Office Use
*Date:*______________
*Next:*______________
*Paid:*______________
*Billed:*______________

CLIENT INFORMATION:

Client's Name:____
Address:____
____
Mobile Phone:______________________ Ok to text?_____ Voicemail?_____
Home Phone:______________________ Ok to use voicemail?_____
Other Phone:______________________ Type:_________ Ok to text?_____ Voicemail?_____
Email:______________________ Referred By:______________________
Date of Birth:______________________ Social Security #:______________________
Marital Status:______________________ # of Children:______________________
In case of an emergency, is there someone you give me permission to contact? If so:
Name:______________________ Relationship:______________Phone:___________

INSURANCE INFORMATION:

Policy Holder's Name:____
Address:____
Relationship to Client:______________________ Employer:______________________
Date of Birth:______________________ Social Security #:______________________
Is this an EAP? Yes / No # of Sessions:___________ Auth #:______________________
Insurance Company:______________________ ID #:______________________
Counselor Notes:____
____
*Phone # for Providers:*______________________ *Auth #:*______________________
*Deductible:*______________________ *Copay:*______________________

I hereby give J. Selah Richards, MS LPC-S permission to exchange required information and submit claims with my insurance company in order to verify benefits and receive payment for services rendered.

Signature:______________________________ Date:______________________
Signature:______________________________ Date:______________________

Please provide a copy of your driver's license/photo ID and insurance card (front and back).

Adults must provide a copy of divorce decree, custody agreement, or other legal documentation showing they have permission to initiate medical/mental healthcare for children or have the consent to treat a minor form signed by both parents (see page 6).

INTAKE INFORMATION:

What chief concern brings you to counseling at this time?____
____
____
____

Have there been stressful events which have occurred recently or are still on-going?_______________________
____
____
____

Please circle any current symptoms you are experiencing:

Depression / Anxiety / Panic Attacks / Changes in Eating or Weight / Changes in Sleep

Fatigue / Tearfulness / Worthlessness / Hopelessness / Guilt / Grief / Chronic Pain or Illness

Crime or Abuse Victim / Dissociation / Delusions or Hallucinations / Obsessions or Compulsions

Impulsivity / Irritability / Anger / Restlessness / Mania / Mood Swings / Difficulty Concentrating

Increased Alcohol or Drug Usage / Other Addictive Behaviors / Legal Problems

Intrusive or Negative Thoughts / Relationship or Work Problems / Severe Financial Problems

Self-Injury / Thoughts of Death or Suicide / Past Suicide Attempt / Thoughts of Harming Others

Other Symptoms:____

When did these symptoms begin? Have they been getting better or worse, or staying the same?
____
____

Have you had these symptoms before? Have you ever been hospitalized for these symptoms?
____
____

Have you ever taken medications for these symptoms? Did they help?____________________________________
____
____

What medications are you currently taking on a regular basis (for any condition)?
____
____
____

Are you currently seeing other healthcare professionals? If so, who and for what condition?
____
____

Do you smoke? No / Quit (When?__________ / Yes (#/day?__________)

Do you drink alcohol? No / Less than 2 drinks per month / Average _______ per week

Have you ever used any illicit substances, or misused/overtaken prescription medications? Please explain:
*[The type, amount, frequency, and duration of use of substances can help identify underlying medical or psychological patterns which are clinically useful and help shape treatment recommendations.]*____
____
____

Have you ever struggled with a substance or behavior which felt like an addiction? Please explain:___________
____
____

Have you ever been the victim of a crime, abuse, or other traumatic events? Please explain:_______________

Have you been involved in any legal matters in the past year, or do you expect to be involved with any legal matters in the next year? Please explain: _______________

Do you have a current spiritual belief system or supportive community of which you are a part?_______________

Briefly describe your relationships with your family of origin:_______________

Briefly describe your currently significant relationships:_______________

Any other information you would like to share with me at this time:_______________

COUNSELOR'S NOTES & MENTAL STATUS EXAM OBSERVATIONS:

AFFECT: ☐ Appropriate ☐ Full ☐ Constricted ☐ Flat ☐ Labile ☐ Inappropriate
APPEARANCE: ☐ Avg Hygiene ☐ Avg Attire ☐ Unkempt ☐ Disheveled ☐ Inappropriate
DEMENOR: ☐ Cooperative ☐ Anxious ☐ Depressed ☐ Hostile ☐ Overly-sedated ☐ Resistant ☐ Tearful
EYE: ☐ Avg ☐ Avoidant ☐ Intense **PSYCHOMOTOR**: ☐ Avg ☐ Agitated ☐ Fidgety ☐ Slowed
SPEECH: ☐ Avg ☐ Slow ☐ Slurred ☐ Rapid ☐ Pressured ☐ Tangential ☐ Incoherent
THOUGHTS: ☐ Avg ☐ Compulsions ☐ Obsessions ☐ Delusions (☐ Grandiose ☐ Persecutory ☐ Somatic)
☐ Dissociation (☐ Depersonalization ☐ Derealization ☐ DID ☐ OSDD) ☐ Intrusions (☐ Ideas ☐ Memories)
☐ Hallucinations (☐ Audio ☐ Visual ☐ Smell ☐ Taste ☐ Touch) ☐ Guilt ☐ Hopelessness ☐ Helplessness
☐ Risk: Others (☐ W/Plan ☐ W/Intent ☐ NO) ☐ Risk:Self (☐ SI ☐ W/Plan ☐ W/Intent ☐ SIB ☐ NO)
THOUGHT PROCESS: ☐ Avg ☐ Blocked ☐ Distorted Flow ☐ Incoherent ☐ Racing ☐ Tangential
COGNITIVE: ☐ Oriented ☐ Attention Avg ☐ Attention Issues (☐ Hyperactive ☐ Impulsive ☐ Poor Focus)
☐ Memory Avg ☐ Memory Impaired (☐ STM ☐ LTM ☐ Recall) ☐ Est Intel (☐ IDD ☐ Avg ☐ Above)
OBSERVED: ☐ Cooperative ☐ Resistant ☐ Overly Sedated ☐ Depressed ☐ Anxious ☐ Tearful ☐ Fearful

DSM Dx:_______________

Tx Plan: ☐ Ind ☐ Couple/Mar ☐ Grp ☐ Psychiatrist/Hosp ☐ Referred Out ☐ No Tx Now

Referrals Given:_______________

Next Appointment/Homework:_______________

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INFORMED CONSENT:

Legally and ethically, I am required to make sure you understand the following key points before you enter into a counseling relationship:

1. **Counseling has both benefits and risks.** Benefits vary from person to person, and vary based on how much you practice new skills between sessions. Risks include making symptoms worse, as intense emotions, unpleasant thoughts, and uncomfortable memories may become more clearly experienced as you talk about your issues. Taking off the blinders hurts, and is a required part of having enough clarity and motivation to make the changes necessary to cause change in your life. I can not guarantee a cure, or even an improvement in your case, nor can I promise how many sessions you may need to reach your goals.
2. **Sessions typically last 45 minutes.** Frequency of sessions will be selected based on your goals, your symptom severity, your desires, and my clinical opinion. Your insurance company may also set limits on number and frequency of sessions. Insurance companies require a clinical diagnosis in order for sessions to be deemed "medically necessary." To have the most control over your privacy, and treatment, self-pay is an option so that you set these parameters, not an insurance company.
3. **Fees for counseling vary** based upon your insurance or any sliding scale adjustments made for self-pay clients with significant economic hardships. My standard fees are: $150 for initial evaluations; $90 for a 45-minute session; $60 prorated fee for out-of-session services (such as report writing; extended phone, text, or email conversations; or case-coordination services you request); **$50 fee for copies of charts or treatment summaries (must be requested in writing and requires a two-week notice); and $50 fee for failing to provide 24-hour notice when canceling an appointment (which may be waived in cases of emergency; frequent cancellations may result in your treatment being terminated).** You are responsible for all fees, and providing timely updates to your insurance information to avoid denial of payment. If you are a parent/guardian, you are responsible for all fees your child incurs, including missed-session/late-cancellation fees. Running a large outstanding balance, when a payment plan hasn't been agreed upon ahead of time, will result in your treatment being terminated. **There is a $50 fee for returned checks.**
4. **I am not a forensic psychologist, and my degree may not qualify me to be considered an expert witness.** Please do not enter counseling with the main intention of attaining information to use in a court case. If you become involved in litigation that requires my participation (including but not limited to divorce, custody disputes, cases involving CPS, or criminal activity) I charge **$200 per hour** for preparation, time blocked for attendance (even if event is cancelled/rescheduled), and for attendance at any legal proceedings. Also, **a $1,500 retainer** will be required upfront if a subpoena is issued or court appearances are requested.
5. You are entitled to receive, or request other healthcare professionals receive, copies or information from your records. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. If I believe they are a danger to you, I may instead offer you a treatment summary. **I prefer to send other healthcare professionals a treatment summary in order to protect your privacy, make the information easier for them to understand, and because many of my notes are heavily process related.**
6. **Confidentiality is very important to the counseling relationship. However, there are limits to confidentiality:**
   a) If a client appears to be in imminent or s**ignificant danger of harming themselves, or someone else**, I am required to take protective action, which may include encouraging you to seek hospitalization or notifying medical or law enforcement agencies.

   b) If a client discloses information that leads me to believe that a **child, elderly, or disabled person is being abused or neglected**, I am legally required to report this activity.

c) If I receive a subpoena, am forced to testify or give a deposition concerning you or services rendered, or if you grant me permission to exchange confidential information, I will release as much information is required while trying to honor your privacy as applicable.

d) As part of my continuing development, and to provide you with the best care, I may consult with other professionals, who are also bound to keep confidentiality. Your personally identifying information is protected in these scenarios.

e) **Your insurance company requires certain minimal data in order to deem counseling a covered service.** They are also allowed some information about your sessions such as date of service, type of service provided, diagnosis, current medications, symptoms addressed, and ongoing treatment plans. They do not require knowledge of everything we discuss. Nor are they allowed to give clinical information to your employer.

f) Marriage/Couples/Family/Group therapy session do not have confidentiality for conjoint sessions (i.e., everyone present can request information from that session). **If you are involved in Marriage/Couples/Family counseling, confidentiality does not extend to other members of treatment even in individual sessions, and is based upon my discretion based on the information/situation.** Marriage/Premarital couples will be asked to pay for and complete an **online assessment, which is $30-35 per couple,** usually following their first joint session.

g) Parents are encouraged to allow their children to have confidentiality in counseling in order to allow the child a safe place in which to be honest about what is going on in their lives. **When a child or adolescent is engaging in significantly reckless behavior or persistent substance use, we will discuss the situation and I will give him/her the opportunity to inform their parent/guardian in my presence since this may constitute harm to self.** Please understand that I will not betray confidences of parental defiance or rebellion that are not life threatening.

h) **Every effort is made to keep electronic files, transmissions, and communications protected and HIPAA compliant.** While I do everything to keep your information safe, you understand that some forms are out of my total control such as voicemails, emails, text messages, online marital assessments and other situations in which we are not in the counseling office. A HIPAA-compliant clearing house is used for all billing purposes, when supported by your insurance company.

By initialing here, I am recognizing and agreeing to the risks involved in utilizing electronic communication should I request the therapist utilize this form of communication when scheduling appointments, handling crisis situations, submitting claims to my insurance company, for release of information situations which the client initiates, or for any other situation that the client initiates. **Client 1 Initials:_____________ Client 2 Initials:_____________**

7. You may call, text, fax, or email me at the contact information provided on my website or on this form. I will make every effort to reply within 24-48 hours, with the exception of weekends and holidays. **In urgent emergencies, my services should not be used for crisis intervention. You can leave me a message after contacting 911, your physician, the emergency room of your choice, or a licensed mental health facility.**
8. **Inclement weather closings are usually done based upon the local school district's decision.** I will notify you by phone, text, or on my outgoing phone message if the office has closed for bad weather.
9. **Weapons are not allowed in my office.** Please leave any concealed handguns, pocket knives, razor blades, and other dangerous objects at home or in your vehicle. Self-injury or threatening others on premise may result in emergency responders being notified, and possible termination of services.
10. **Files are kept for a minimum of 5 years**, as required by the State of Texas LPC Board. After that, they will be shredded and destroyed in a HIPAA-compliant manner. In event of my illness or death, existing files will enter HIPAA-compliant conservatorship until their expiration date with **Sharon L. Walker, LCSW (817-277-0660), and as such she is a covered entity for this consent.**
11. Complaints, questions, or concerns about your therapy should be brought up with me so we can discuss them and try to find a solution. If you decide that you want to terminate treatment, or I decide that it is clinically in your best interest for you to work with someone with different skills, I will attempt to provide you with an appropriate referral. Any individual who wishes to file a complaint against a Licensed Professional Counselor may write to: Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369, or call 1-800-942-5540 to request the appropriate form.

COUNSELING CONTRACT:

You, the client(s) agree to provide accurate personal and insurance/financial information, to actively participate in your counseling and treatment goals/plans, to make every effort to be at all scheduled appointments (and provide 24-hour notice when canceling in order to avoid being charged a missed-session fee no higher than the contracted session rate), to complete homework assignments, to practice new skills and build new support networks outside of sessions, to notify the counselor in writing if you wish to terminate therapy early, and to discuss any concerns you have about the counseling process or these policies with the counselor. You also sign agreeing that you have read the **Notice of Policies and Practices** to Protect the Privacy of Your Health Information and the **Informed Consent** documents.

Client:_______________________________ Date:_______________________

Client:_______________________________ Date:_______________________

Parent/Guardian:_______________________ Date:_______________________

Counselor:____________________________ Date:_______________________

CONSENT TO TREAT A MINOR DEPENDENT:

I certify that I am the parent, managing conservator or legal guardian of

Child's Name:_____________________________ Date of Birth:________________

I hereby give my authorization and informed consent for the above named child to receive counseling services, and further certify that I have full legal authority to authorize and consent to this evaluation and/or treatment.

Mother Signature:__________________________ Date:_____________________

Father Signature:__________________________ Date:_____________________

Guardian Signature:________________________ Date:_____________________

Adults must provide a copy of divorce decree, custody agreement, or other legal documentation showing they have permission to initiate medical/mental healthcare for children or have the above consent to treat a minor form signed by both parents.

*Document:*__________________________________ *Reviewed:*____________________

UPDATED SIGNATURES FOR NEW CALENDAR YEAR:

I have reviewed my information contained in these original intake forms and agree that they are still accurate and valid. I continue to abide by the agreements contained herein, and have been made aware of any changes/additions to the Notices of Policies and Practices to Protect the Privacy of Your Health Information and/or the Informed Consent documents. I am aware that I may print new, up-to-date copies of these forms at http://www.SelahCares.com/ at any time, or ask for a new paper copy to be provided to me to review. I continue to allow J. Selah Richards, MS LPC the right to exchange required information with my insurance company in order to attain and perform billing/claims processes, service coordination, and to receive authorizations as needed.

Signature:_________________________________ Date:_____________________

Signature:_________________________________ Date:_____________________

Signature:_________________________________ Date:_____________________

Signature:_________________________________ Date:_____________________

I also continue to give consent for my child to be receiving services:

Parent/Guardian:___________________________ Date:_____________________

Parent/Guardian :__________________________ Date:_____________________

Notice of Policies and Practices to Protect the Privacy of Your Health Information:

THIS NOTICE DESCRIBES HOW COUNSELING AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations: We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions: "*PHI"* refers to information in your health record that could identify you. "*Treatment, Payment and Health Care Operations" Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist. "*Payment"* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. "*Health Care Operations"* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. "*Use*" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. "*Disclosure*" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
II. Uses and Disclosures Requiring Authorization: We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. we will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.
III. Uses and Disclosures with Neither Consent nor Authorization: We may use or disclose PHI without your consent or authorization in the following circumstances:

1. **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
2. **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
3. **Health Oversight:** If a complaint is filed against one of our counselors with the State Board of Licensed Professional Counselors, the Board has the authority to subpoena confidential mental health information from us relevant to that complaint.
4. **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**
5. **Serious Threat to Health or Safety:** If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to your emergency contact or medical or law enforcement personnel.
6. **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Counselor's Duties Patient's Rights:

1. *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
2. *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at this office. Upon your request, we will send your bills to another address.)
3. *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your access to PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
4. *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
5. *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
6. *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

V. Counselor's Duties: We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will post notice of such revision on our practice web site, http://www.selahcares.com . We may also elect to notify you by mail at the billing address which you have provided to us.
VI. Complaints: If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact J. Selah Richards at 469-855-7795 to further discuss these issues. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. An individual who wishes to file a complaint against a Licensed Professional Counselor may write to: Complaints Management and Investigative Section P.O. Box 141369, Austin, Texas 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information.
VI. Effective Date, Restrictions and Changes to Privacy Policy: This notice will go into effect on December 1, 2008.

Last Updated: 11/11/15

SLIDING SCALE FEES FOR CASH CLIENTS:

I do offer reduced fees for clients who do not have insurance. I base my sliding scale rates off the Federal Poverty Guidelines. I do this in order to help clients who can not afford the full cost of counseling, but who also do not have mental health benefits under other agencies. Many families fall in a gap where they make too much to qualify for assistance programs, but too little to afford counseling. Sliding scale appointments must be paid for in cash or with credit/debit cards. Sessions must be paid for at the beginning of the session. I rarely ever allow an unpaid balance unless we have specifically discussed your emergency situation and your payment plan to catch up.

In order to qualify for sliding scale please bring me your last two pay stubs or disability/unemployment checks (or bank statement showing these deposits), and your most recent income tax form.

Family Size	100%	125%	150%	175%	200%	225%	250%	275%	300%	325%	350%
1	$11,490	$14,363	$17,235	$20,108	$22,980	$25,853	$28,725	$31,598	$34,470	$37,343	$40,215
2	$15,510	$19,388	$23,265	$27,143	$31,020	$34,898	$38,775	$42,653	$46,530	$50,408	$54,285
3	$19,530	$24,413	$29,295	$34,178	$39,060	$43,943	$48,825	$53,708	$58,590	$63,473	$68,355
4	$23,550	$29,438	$35,325	$41,213	$47,100	$52,988	$58,875	$64,763	$70,650	$76,538	$82,425
5	$27,570	$34,463	$41,355	$48,248	$55,140	$62,033	$68,925	$75,818	$82,710	$89,603	$96,495
6	$31,590	$39,488	$47,385	$55,283	$63,180	$71,078	$78,975	$86,873	$94,770	$102,668	$110,565
7	$35,610	$44,513	$53,415	$62,318	$71,220	$80,123	$89,025	$97,928	$106,830	$115,733	$124,635
8	$39,630	$49,538	$59,445	$69,353	$79,260	$89,168	$99,075	$108,983	$118,890	$128,798	$138,705
Slide %	**50%**	**55%**	**60%**	**65%**	**70%**	**75%**	**80%**	**85%**	**90%**	**95%**	**100%**
Session Fee	**$45.00**	**$49.50**	**$54.00**	**$58.50**	**$63.00**	**$67.50**	**$72.00**	**$76.50**	**$81.00**	**$85.50**	**$90.00**

[Based on Percentages of the Federal Poverty Guidelines 2013] *Average Session Fee: $90.00*

Based on your estimated annual income of ________________, which you showed me documentation to support, your current cash cost per session is ________________.

Signature:____ Date:__________________________________

Signature:____ Date:__________________________________

Counselor:____ Date:__________________________________

CHANGES/MODIFICATIONS:

As of ___/___/___ estimated annual income is now _______________ and session rates are now __________.

Signature:____ Date:__________________________________

Signature:____ Date:__________________________________

Counselor:____ Date:__________________________________

As of ___/___/___ estimated annual income is now _______________ and session rates are now __________.

Signature:____ Date:__________________________________

Signature:____ Date:__________________________________

Counselor:____ Date:__________________________________

As of ___/___/___ estimated annual income is now _______________ and session rates are now __________.

Signature:____ Date:__________________________________

Signature:____ Date:__________________________________

Counselor:____ Date:__________________________________