



## Client Information Form for Group Services

Group Name: \_\_\_\_\_

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Age: \_\_\_\_\_ Nicknames or aliases: \_\_\_\_\_

Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home/evening phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

May we leave a message?  Yes  No

May we send you a text?  Yes  No

May we email you?  Yes  No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

### Emergency Information

If an emergency arises and I cannot reach you directly or we need to reach someone close to you, whom should we call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

### Other

Is there anything else that is important for the group facilitator(s) to know about, and that you have not written on any of these forms? If yes, please tell me about it or write it here:

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## Informed Consent for Treatment in Group Services

### Disclaimer:

This group is intended to provide a space to facilitate personal growth, self-exploration and expression. This group is not intended to evaluate, diagnose or treat an illness, injury, disease or its symptoms. **Therefore, this service is not considered medically necessary, will not replace a thorough diagnostic evaluation or treatment, if needed, and will not be covered by your health insurance benefits.**

Please note that although there are many potential benefits to participating in a group process, it is not a replacement for individual psychotherapy. If issues arise that are not suitable to the group process, you may benefit from individual therapy sessions. If at any point you need assistance with referrals please let me know.

### Group Services

Group sessions are typically weekly unless otherwise scheduled by the facilitator in advance. Group sessions involve one or more group facilitators working with several people at the same time. Some benefits of this service may include:

- Receiving support and encouragement of other members.
- Observing others as role models and gaining new perspectives.
- Having a safe place to learn new strategies and practice new thoughts, feelings, and behaviors within the security of the group.

Some potential risks may be:

- You may feel anxious or nervous about sharing difficult experiences in front of the group.
- It might feel triggering or overwhelming to participate in certain group discussions.
- There may be difficult or challenging feelings that arise during or after group.
- Other group members may fail to adhere to confidentiality policies.

### Confidentiality

In general, the confidentiality of all communications between a member and a provider is protected by law. I can only release information about our work to others with your written permission. However, there are some exceptions and situations in which I would be legally required to take action that might necessitate revealing information about a member's participation. These include, but may not be limited to:

- If you disclose intention or a plan to harm another person or yourself, I'm required to make reasonable attempts to keep you or the other person safe. I may be required to inform the other person, their family, or emergency contact.



- If you state or suggest anyone under the age of 18 is in danger of abuse or neglect, I'm required to report this information to the appropriate social service agencies.
- If I receive a court order or subpoena by a judge.

**\*\*Confidentiality among group members – In order to maintain a safe and trusting environment, group members are asked to keep what is said in the group, in the group. If you decide to talk about events that occur in the group with others outside of it, please do not give names or personal information about other group members to anyone. Please do not talk about events in any way that would compromise the confidentiality of other group members. This includes social media as well.**

### **Group Rules**

Developing an effective group process requires the commitment of all members. **You have a reserved spot in this group for its duration.** This means you are agreeing to honor your commitment to the group process. Your attendance is very important and it impacts the flow and bonding of all the members.

- You agree to miss no more than 1 group meeting per 6 week session, 2 per 8 week session, or 3 per 12 week session. Should you miss more than this you may be asked to leave group, and you will be required to pay for the remaining sessions, as that space was reserved for you.
- 24-hour notification is required for any missed session or you will be responsible for a \$25 fee.
- Please turn off all electronic devices in order to respect the process and other group members. Recording of any kind in group is not permitted.

### **Fees and Payments**

Fees vary by group and payments are due at the start of each group meeting. Payment can be in the form of cash, check, or credit/debit card. I require each group member to keep a credit card authorization form on file.

In order to expedite the check-in process, I ask that members who wish to pay with credit/debit cards fill out the authorization form to keep that card on file and I will charge the card weekly for the duration of the group.

Members may also choose to pay for the entirety of the group up front with any of the above-mentioned methods of payment.



**Terminating Group**

Because of the bonding aspect of group, if you are unable to continue attending the remainder of the group sessions due to an unforeseeable crisis or emergency, I ask that you attend a final group for the other group members to have closure.

**Contact**

My individual, professional phone number will be provided to you for you to contact me regarding scheduling issues and in the case of emergencies. However, please note I am typically not immediately available but will do my best to contact you at my earliest availability. If this is an emergency and you cannot reach me immediately, please call the main number at (215) 399- 4128 and leave a message indicating your current crisis and the on-call provider will call you back. If you cannot wait for a return call, please go to your nearest emergency room, call 9-1-1, or the Philadelphia 24-Hour Crisis Hotline number at (215) 686-4420.

BY SIGNING THIS FORM BELOW, YOU ARE AGREEING THAT YOU HAVE READ, UNDERSTOOD, AND AGREED TO THE ITEMS CONTAINED IN THIS DOCUMENT AND AS FOLLOWS:

- You consent to group services at Turning Leaf Therapy.
- You recognize that everything discussed in group is strictly confidential and you agree to not disclose the name of, or any other information related to, any member of the group to anyone outside of the group.
- You agree to follow the group rules and understand the limits of confidentiality.
- You understand you are making a commitment to this group and that your spot is held for you for its duration and that a fee is required for each session.
- You understand that insurance will not cover this group therapy service and that you are responsible for paying all fees as previously outlined.

If you have any questions or concerns, please discuss this with your group facilitator. By signing below, you are indicating you understand and agree to group policies and practices as noted above.

\_\_\_\_\_  
(Client Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Clinician Signature)

\_\_\_\_\_  
(Date)



**Group Therapy Credit Card Authorization Form**

Name: \_\_\_\_\_ Name of Group: \_\_\_\_\_

I authorize Turning Leaf Therapy, LLC to keep my signature on file and to charge my account for the following group therapy services:

Payment in full for the duration of the group in the amount of \_\_\_\_\_.

OR

Payment for each session in the amount of \_\_\_\_\_.

**AND**

Missed sessions/no show fees \_\_\_\_\_.

I understand that I can choose to pay at the beginning of each session with another approved payment method (i.e., cash or check). I understand that my card will be charged only in the event that I fail to provide payment in full at the time of my session. I will be notified, verbally, by my provider that the missed session or the past due session payment will be applied to my credit card.

I agree that this form is valid for the length of the group therapy and authorization for the use of this card will be canceled at the termination of therapy.

1. Client's Name: \_\_\_\_\_

2. Card Holder's Name: \_\_\_\_\_

3. Card Holder's Address: \_\_\_\_\_

4. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Visa     Master Card     American Express     Discover

Acct. # \_\_\_\_\_ CSC# \_\_\_\_\_  
(3-digit # on back of card)

Signature: \_\_\_\_\_ Exp. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_