



Liberated Counseling, LLC

Information Sheet

Partner 1 Information:

Legal Name: _____	DOB: _____
Preferred Name: _____	Social Security Number: _____
Gender Identity: _____	Biological Sex: _____
Pronouns: _____	Ethnic Identity: _____
Sexuality: _____	Religious Identity: _____
Other Identity: _____	Other Identity: _____
Primary Language: _____	Proficiency of reading / writing in this language: _____

Email, text messaging, and other electronic communications are not secure mediums and therefore, confidentiality cannot be assured. Please use discretion when sending information that is sensitive in nature.

Cell Phone: _____	May I leave a message?	YES	NO
Marital Status: _____	May I text you?	YES	NO
Email: _____	May I email you?	YES	NO
Home Address: _____			
Significant Relationship(s): _____			
Relationship Agreement(s): _____			

Partner 2 Information:

Legal Name: _____	DOB: _____
Preferred Name: _____	Social Security Number: _____
Gender Identity: _____	Biological Sex: _____
Pronouns: _____	Ethnic Identity: _____
Sexuality: _____	Religious Identity: _____
Other Identity: _____	Other Identity: _____
Primary Language: _____	Proficiency of reading / writing in this language: _____

Email, text messaging, and other electronic communications are not secure mediums and therefore, confidentiality cannot be assured. Please use discretion when sending information that is sensitive in nature.

Cell Phone: _____	May I leave a message?	YES	NO
Marital Status: _____	May I text you?	YES	NO
Email: _____	May I email you?	YES	NO
Home Address: _____			
Significant Relationship(s): _____			
Relationship Agreement(s): _____			

Emergency Contact(s):

_____	_____	_____	Ok to Contact?	YES	NO
(Name)	(Relationship)	(Telephone Num.)			
_____	_____	_____	Ok to Contact?	YES	NO
(Name)	(Relationship)	(Telephone Num.)			



Liberated Counseling, LLC

CONSENT TO TREATMENT

It is the policy of Liberated Counseling LLC that clients have the right to say whether they wish to receive Outpatient services. Each client has impartial access to treatment, regardless of race, religion, gender identity, ethnicity, age, sexual preference or disability, within the range and diagnostic criteria for which Liberated Counseling LLC provides treatment.

The undersigned acknowledges that Liberated Counseling LLC makes no guarantees to the undersigned or the client as to the results or likelihood of success of Liberated Counseling LLC services.

The undersigned acknowledges that if a client becomes dangerous to him/herself or to others, the staff will exercise the necessary precautions to protect the client or others.

The undersigned acknowledges receiving a copy of information about Liberated Counseling including policies and procedures, Informed Consent, HIPPA compliance protocols, and Notice of Privacy Practices.

The undersigned releases Liberated Counseling LLC staff from any liability for the loss or damage of personal property and/or money while receiving services at Liberated Counseling LLC or at the client's home.

These services are completely voluntary:

Yes; we Consent to receive outpatient services from Liberated Counseling LLC.

No; we Do Not Consent to receive outpatient services from Liberated Counseling LLC. Referrals for outside services or alternative services can be supplied upon request.

Our signatures below attest to the fact that we have read this form, understand its content and agree to the stipulations herein.

PARTNER 1 SIGNATURE

DATE

PARTNER 2 SIGNATURE

DATE

I have discussed the notice of privacy practices, informed consent, consent to treatment, consent to policies, consent to payment policies, consent to Relationship therapy, consent to cancellation policy, and client rights and responsibilities with these individuals. My observations of their behavior and responses give me reason to believe that they are fully competent to give informed and willing consent. My signature below attests to this statement.

STEPHEN RATCLIFF, MA, LPCC (NM), LPC (OR), NCC, CST

DATE



Liberated Counseling, LLC

CONSENT TO POLICIES

Thank you for choosing Liberated Counseling as your therapy provider. Please carefully review the consent to disclosure to insurance companies (if applicable) and receipt of notice of privacy practices below. If you agree to each item, please have both people initial next to each statement indicating your agreement and sign at the bottom.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ We acknowledge that we have been provided a Notice of Privacy Practices that fully explains the uses and disclosures that Liberated Counseling will make with respect to our individually identifiable health information. We understand that we have the right to review said notice before signing this consent. Additional copies of this notice are posted on the website www.liberatedcounseling.com and in the office lobby. We also understand that Liberated Counseling reserves the right to change its notice and the practices detailed therein prospectively and will notify us of any changes.

RECEIPT AND CONSENT TO INFORMED CONSENT AND ADDITIONAL POLICIES

_____ We acknowledge that we have been provided and reviewed a copy of Informed Consent, additional privacy policies and cancellation and no-show policy. We understand these policies and agree to abide by the boundaries and stipulations therein.

_____ We understand the limits of confidentiality in communication by electronic means. We will use discretion when electronically communicating information to this therapist.

CONSENT TO CANCELLATION POLICY

_____ We understand that if we are unable to attend our scheduled therapy appointment, we must notify Liberated Counseling by email or at [505-504-5449](tel:505-504-5449) by text or voicemail 24 hours in advance of our appointment.

_____ We understand that if we do not call to cancel or reschedule our appointment, this will be considered a **no-show**. Additionally, arriving later than 20 minutes for our scheduled therapy appointment time constitutes a no-show. No-shows to appointments will result in a subsequent fee of **\$25**.

_____ We understand that reoccurring no-shows / same day cancellations (2 instances in 12 months) may result in the termination of services. We understand that if we miss our scheduled appointment, it is our responsibility to call to set up another appointment. We understand that if we don't respond to contact attempts from Liberated Counseling, this will be interpreted as communication that we no longer wish to receive services.

_____ We understand that if extenuating circumstances arise and we cancel in advance of our appointment but not with 24 hours' notice, Liberated Counseling may choose to waive this fee on a case-by-case basis.

_____ We understand that if we miss our scheduled appointment, it is our responsibility to call to set up subsequent appointments. Failure to cancel with 24-hour prior notice *may* result in me losing our preferred time slot. If we are failing to maintain contact, Liberated Counseling may take this as communication that I am terminating services.

We affirm that we have read, fully understand, and agree with these policies for relationship counseling.

PARTNER 1 SIGNATURE

DATE

PARTNER 2 SIGNATURE

DATE

STEPHEN RATCLIFF, MA, LPCC (NM), LPC (OR), NCC, CST

DATE



Liberated Counseling, LLC

CONSENT TO PAYMENT POLICIES

Please carefully review the boundaries and expectations outlined below. Please have both people initial next to each statement indicating your agreement and sign at the bottom. These are considered a necessary condition for treatment.

GENERAL PAYMENT POLICIES

_____ We understand that all fees are due at the time or service. We understand that unless other arrangements are made in advance, we will be expected to pay the noted fee for these services at each appointment. Any payments may be made via cash, check, or credit card.

_____ We understand that the full-scale fees for services are as follows: Intake Assessment **\$200**, After hours Therapy **\$200** per 55 minutes, Counseling / Therapy Appointments **\$175** per 55 minutes, Relationship Therapy Appointments **\$175** per 55 minutes, and a one-time **\$45** fee for the Gottman Relationship Checkup Assessment Measures for relationship therapy clients.

_____ We understand that any balances not paid within 30 calendar days may be turned over to collections with an additional 2% late fee added. We understand that if our bill must be turned over to collections due to not paying our balance after 30 calendar days, we are responsible for the collection's fees (typically 40% of the total bill).

_____ We understand that if payment for the services I receive is not made, the therapist may stop services.

_____ We understand that if we pay by check or with credit card and the payment is later recouped (ex. the check bounces), a fee of **\$50 per incident** will be incurred. We understand that this balance must be paid by alternative means in 5 days. We understand that recoupment may result in this payment method not being for future payments.

ADDITIONAL SERVICES POLICIES

_____ We understand that any out of session communication (telephone call or other medium) lasting more than 5 minutes will result in a fee of **\$25** per 15 minutes. There will be no fee for contacts lasting less than 5 minutes.

_____ We understand that other services such as record preparation, report writing, and other documentation are charged at the rate of **\$25** per 15 minutes.

_____ We understand that if we choose to subpoena Stephen Ratcliff, all legal services including preparation time, testimony time, transportation time, and commute time will incur a fee of **\$500** per hour due prior to testimony date.

We affirm that we have read, fully understand, and agree with these payment policies for relationship counseling.

PARTNER 1 SIGNATURE

DATE

PARTNER 2 SIGNATURE

DATE

STEPHEN RATCLIFF, MA, LPCC (NM), LPC (OR), NCC, CST

DATE



Liberated Counseling, LLC

CLIENTS RIGHTS AND RESPONSIBILITIES

Client's Rights

1. The right to efficient and equal service, regardless of race, gender, religion, ethnic background, education, social class, physical or mental disability, sexual orientation, gender identity, or economic status.
2. The right of considerate, courteous, and respectful care from all Liberated Counseling, LLC staff.
3. The right to informed consent and full discussion of risks and benefits prior to any invasive procedure, except in an emergency. Alternative to the proposed procedure must be discussed with the client.
4. The right to receive information in an understandable manner.
5. The right to obtain a referral for bi-lingual services or to have an interpreter present in session if needed.
6. The right to the names, titles, and professions of Liberated Counseling, LLC staff with whom the client speaks and from whom services or information are received.
7. The right to refuse examination, discussion, and/or procedures to the extent permitted by law and to be informed of the health and legal consequences of this refusal.
8. The right of access to the client's own personal health record.
9. The right to confidentiality and privacy of the client's personal mental health records as provided by the law. The details of the client's life and treatment are shared only with the client's parent's or guardian's permission and the client's explicit consent.
10. The right to expect reasonable continuity of care within the scope of services of Liberated Counseling, LLC.
11. The right to examine and receive a full explanation of any charges made by Liberated Counseling, LLC regardless of the source of payment.
12. The right of respect for the client's civil rights and religious opinions.
13. The right to be represented by a family member or guardian if the client is unable to fully participate in treatment decisions.

Client's Responsibilities

1. Provide accurate and complete information relevant to your treatment at Liberated Counseling, LLC.
2. Ask questions if you do not understand any aspect of your treatment.
3. Report safety concerns immediately to your therapist.
4. Avoid drugs, alcoholic beverages, or toxic substances while in attendance of your therapy session.
5. Accept the consequences if you do not follow the care, service, or treatment plan provided to you.
6. Respect the property of other people and of Liberated Counseling, LLC.
7. Be considerate of other clients.
8. Sign a written acknowledgement that you have received the applicable Notice of Privacy Practices.
9. Provide accurate information needed for processing your insurance coverage.
10. Be responsible for payment of all services, either through your third-party payers (insurance company) or by personally making payment for any service that are not covered by your insurance policy(s) including second opinions or consultations.

We affirm that we have read and fully understand our rights and responsibilities listed herein.

PARTNER 1 SIGNATURE

DATE

PARTNER 2 SIGNATURE

DATE

STEPHEN RATCLIFF, MA, LPCC (NM), LPC (OR), NCC, CST

DATE



Liberated Counseling, LLC

INFORMED CONSENT FOR RELATIONSHIP COUNSELING

General Information

Please review the following boundaries and information carefully and thoroughly. Please feel free to ask any questions!

- I utilize Gottman method, attachment-focused, emotion-focused, and other supplementary relationship therapy methods. I seek to create a tailored treatment approach that builds on your relationship’s strengths and addresses your unique situation and struggles.
- Once we have started Relationship therapy, I will be unable to offer individual therapy for any of the relationship members. This is due to a conflict of interest. I would be happy to offer a referral if desired.
- In relationship therapy, the relationship is the client rather than any of the relationship’s members.

Expectations of the Process

- I will never advocate for you to stay together at all costs or to divorce. These decisions are yours to make and my job is to support you in making your relationship decisions rather than dictate a certain path for you.
- While I seek to support you in your relationship goals, I cannot guarantee any outcome from treatment.
- The continued participation by all members of the relationship is voluntary. Any participant may suspend or terminate the therapy at his or her individual request at any time.

Unique limitations regarding Confidentiality

Due to relationship work involving two or more people, the following boundaries are important to clarify.

- In order for counseling information or records to be released, all members of the relationship must provide their written authorization. If all members of the relationship who participated in this therapy (as identified below) do not provide consent, then records cannot be released.
- Because there are two or more individuals who are the focus of treatment, privilege cannot be guaranteed. This means that confidentiality is somewhat more limited compared to individual therapy where information disclosed is considered privileged. Thus, anything involved with relationship counseling may not be privileged communication.
- I receive occasional professional consultation to help me improve my provision of services. Neither your name nor any identifying information about you and your relationship are revealed during these consultations.
- Because the process of relationship counseling involves a high amount of vulnerability in the efforts to build a closer emotional bond in the relationship, it is understood that all partners will not use the information disclosed during the therapy process against any other partner in a judicial setting of any kind, be it civil, criminal, or circuit. Likewise, neither party shall for any reason attempt to subpoena my testimony or my records to be presented in a deposition or court hearing of any kind for any reason, such as a divorce or custody case.
- Because of the limitations due to my scope of practice, I am unable to make any kind of formal recommendation or state any opinion regarding child custody (Custody recommendations are only permitted by a psychologist custody evaluator).

No Secrets Boundary

My allegiance is to your relationship and not to any of the partners of your relationship as individuals. I find this is particularly important in creating a space where all partners can feel safe. Therefore, I adhere to a strict “No Secrets” policy. This means that I will not hold secrets for any partner. This policy is intended to allow me to continue to treat the relationship by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the relationship being treated.

We affirm that we have read, fully understand, and agree with this Informed Consent for Relationship Counseling.

PARTNER 1 SIGNATURE

DATE

PARTNER 2 SIGNATURE

DATE

STEPHEN RATCLIFF, MA, LPCC (NM), LPC (OR), NCC, CST

DATE



Liberated Counseling, LLC

RELATIONSHIP COUNSELING PAYMENT AGREEMENT

Partner 1 Name: _____

Partner 2 Name: _____

We agree to pay \$ 175.00 per session, **for relationship psychotherapy services** received through Liberated Counseling, LLC.

We also agree to and understand the following conditions:

- Sessions are defined as one hour in length. Extended fees may be incurred for longer sessions.
- The client, or responsible party, will be held responsible for all fees charged.
- Sliding scale fees are to be determined using the client's household income and the number of people in the household. All sliding scale arrangements must be made in advance of the session.
- Fees are due at the time of each session and will be accepted in the form of cash, check, credit card, or money order.
- Fees will only be refunded in the event that the service is not delivered.
- Non-payment of fees could result in the discontinuation of services to the client.
- Clients will be billed for any unpaid services via an invoice by mail. Any unpaid balances may be turned over to collections after 30 days.
- Insurance will NOT be billed for these services; consequently, none of the fees for services will be applied to an insurance plan's annual deductible.
- Because no diagnosis will be rendered and an individual is not being treated, insurance cannot be billed for these services.
- *A \$25 discount is currently offered during COVID-19 from March 2020 – December 2021. This discount may be extended by the clinician at their discretion.*

We affirm that we have read, fully understand, and agree with this payment agreement for relationship Counseling.

PARTNER 1 SIGNATURE

DATE

PARTNER 2 SIGNATURE

DATE

Stephen Ratcliff, MA, LPCC (NM), LPC (OR), NCC, CST

DATE