LAMPOST
WELLNESS CENTERS

AGREEMENT TO ENTER GROUP PSYCHOTHERAPY

While in group therapy at Lampost Wellness Centers:

1. I understand that the clinicians at Lampost Wellness Centers are state licensed clinical professionals and are mandated to report child abuse, elderly abuse, and any intent to harm self or others.

2. I understand that by entering group therapy I am choosing to potentially make changes to my thoughts, feelings, and behaviors. I am ultimately responsible for my life and the changes I make.

3. I agree to provide a credit/debit card to pay for treatment and understand fees of $175 will be charged during the 24 hours preceding my group appointment time.

4. I agree to attend my group unless I have given 48 hours-notice, either in person or on the phone. I understand my obligation to pay fully for my therapist's time if I fail to provide this cancellation notice. In rare and emergency situations, my therapist may make an exception to this obligation.

5. If at any time I chose to terminate therapy, I agree to announce my intention during one group session and then return for at least one more session, after which therapy may end. I agree to be charged for a final session. This charge is to encourage my attendance in order to provide adequate and safe closure to treatment.

6. I understand and agree that Lampost Wellness Centers will keep all my personal information confidential but, without personal identification, the organization may use my issues and solutions for clinical supervision.

7. This agreement will remain in effect until I provide notice and terminate therapy.

_____ _____

Name (Signature) Date

_____ _____

Therapist Signature Date

5410 McKinley Street Bethesda MD 20817
PH 301-841-8930 FAX 240-235-3707
www.lampostwellness.com

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GROUP INTAKE FORM

Information you provide here is protected as confidential information.

Patient Name: _____

Name of parent/guardian (if under 18 years):
_____

Patient Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Address:
_____

_____
(City) (State) (Zip)

Mobile Phone: _____ May we leave a message? □Yes □No

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner:

_____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list:
_____

_____

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WHAT HAS PROMPTED YOU TO SEEK GROUP TREATMENT?

_____Date_____
Patient Signature

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