

Welcome to The Center for Relationship and Sexual Health (CRSH). When people start coaching, they usually have a lot on their minds and do not always remember details about office arrangements. Therefore, we are providing our policies in writing. Please take the time to read these thoroughly before your first appointment. If you have any questions, please bring them to the attention of your Coach. This document contains important information. Once signed, it constitutes a binding agreement between us.

1. **Fees:** Fees may vary depending on a number of factors (i.e., whether individual, or couples sessions, length of sessions, etc.) Your Coach can review with you the details specific to your situation. The initial fee includes any background information you wish to include in writing which we will read prior to your initial coaching session at no additional cost to you.
2. **Cancelled & Missed Appointments:** An appointment is a reserved time slot held just for you. If you must cancel, **48 hours advance notice is required** to avoid any financial obligation for that time slot. Failure to provide notice 48 hours in advance constitutes a missed appointment and will result in you being billed the full fee of your scheduled session. However, if our schedules allow for another appointment in the same week and you attend, you will not be responsible for payment for that missed appointment.
3. **Payment:** We deeply value our relationship with you and honoring the payment commitment & process allows us to focus on you and not on billing. To best serve you, the following payment process applies:
  - a. Payment for professional services is expected at the time of each session.
  - b. A credit/debit card is required to be on file to secure payment for services. **For your protection and peace of mind, your credit card information will be secured in our encrypted system.**
  - c. If paying by credit card, your fee will be processed to your at the time of your session.
  - d. Missed Appointment fees will be automatically charged to your credit/debit card in accordance with the CRSH Cancellation and Missed Appointment Policy.
4. **Insurance:** Insurance does not cover coaching services. Insurance is only for mental health psychotherapy.
5. **Sessions:** Coaching is scheduled at the mutual convenience of the coach and the client. The day and time for the next call will be confirmed at the close of each coaching session. Coaching by phone is paid in advance of each series of coaching calls. Services requested by the client, in addition to coaching calls, will be billed at a prorated hourly rate agreed to in advance.  
The session is initiated with the client calling the Coach. Be reminded that 48 hour notice is required to cancel or change the time of an appointment to avoid financial obligation for the reserved time slot.
6. **Termination of Coaching:** A scheduled orderly end of coaching is very important and can have a positive effect as you move forward. It is suggested that you openly discuss with your Coach at least three session prior to your last session your wish to end coaching. Closure sessions help you acknowledge and summarize what you have accomplished and give you the opportunity to review any unfinished concerns you may have.

By signing this agreement, you acknowledge that you have read this document and understand and agree to all the policies and procedures of The Center for Relationship and Sexual Health.

\_\_\_\_\_  
Print Client Name

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Client Name

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Coach Signature

\_\_\_\_\_  
Date



Your answers to the questions presented here will give us some preliminary information about you enabling us to prepare for your first meeting with a therapist at CRSH. If you have not sent the completed form to us by email, please bring it with you to your first session.

What type of therapy/counseling are you pursuing at this time?

Individual  Couples  Group  Coaching

Please share with us your reasons for seeking psychotherapy/counseling at this time: (check all that apply)

|  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> Depression    | <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Relationship Issues | <input type="checkbox"/> Marital Issues  | <input type="checkbox"/> Mood Disorders |
| <input type="checkbox"/> Sexual Issues | <input type="checkbox"/> Trauma          | <input type="checkbox"/> Parenting/Children  | <input type="checkbox"/> Grief/Loss      | <input type="checkbox"/> Career/Work    |
| <input type="checkbox"/> Addictions    | <input type="checkbox"/> Sexual Identity | <input type="checkbox"/> Anger               | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Other          |

In your own words, briefly describe your reasons for seeking therapy/counseling:

IF YOU ARE IN A RELATIONSHIP, PLEASE PROVIDE INFORMATION ABOUT YOUR PARTNER/SPOUSE ON THE SECOND PAGE OF THIS FORM

PLEASE PRINT CLEARLY

Today's Date: \_\_\_\_\_

NAME: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Last First Middle Initial Month/Day/Year

ADDRESS \_\_\_\_\_  
Number and Street Name City State Zip Code

Primary Phone No: (\_\_\_\_\_) \_\_\_\_\_ Cell  Home  Work  Other

May we contact you & leave a message at this number? Yes  No

Emergency Phone No: (\_\_\_\_\_) \_\_\_\_\_  
Contact Person Name: \_\_\_\_\_ Relationship \_\_\_\_\_

E-Mail Address: \_\_\_\_\_  
May we contact you & send information to this email address? Yes  No

Gender: Male  Female  Transgender  Gender Fluid  Questioning

| RACE                                      |                                   | RELIGION                               |                                     | MARITAL STATUS                     |                                    |
|---|-----------------------------------|--|-------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Agnostic/None | <input type="checkbox"/> Jewish     | <input type="checkbox"/> Single    | <input type="checkbox"/> Married   |
| <input type="checkbox"/> American Indian  | <input type="checkbox"/> White    | <input type="checkbox"/> Baptist       | <input type="checkbox"/> Protestant | <input type="checkbox"/> Partnered | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Asian            | <input type="checkbox"/> Other    | <input type="checkbox"/> Catholic      | <input type="checkbox"/> Other      | <input type="checkbox"/> Divorced  | <input type="checkbox"/> Widowed   |

| ROMANTIC / SEXUAL ORIENTATION         |  |  |   |
|---------------------------------------|--|--|---|
| <input type="checkbox"/> Heterosexual | <input type="checkbox"/> Gay / Lesbian | <input type="checkbox"/> Bi-Attraction / Bi-Sexual | <input type="checkbox"/> Unsure / Questioning |





# Authorization for Credit Card Use

Please print (except for signature line)

Name on Credit Card: \_\_\_\_\_

Billing Address:

Street Address \_\_\_\_\_ Apt Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Credit Card Type:

Visa     MasterCard     Discover     AmEx

Circle One:

Credit    Debit    HSA

Credit Card Number: \_\_\_\_\_ Exp. Date \_\_\_\_\_

Security /Validation Code: \_\_\_\_\_

**ONE TIME CHARGE:** Amount to Charge: \$ \_\_\_\_\_ (USD)

I authorize The Center for Relationship and Sexual Health to charge the amount written above to the credit card provided herein for services rendered to \_\_\_\_\_. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RECURRING CHARGES:**

I authorize The Center for Relationship and Sexual Health to charge future session fees, missed session fees, and/or insurance deductibles, co-pays, and/or co-insurance payments to the credit card provided herein for services rendered to \_\_\_\_\_. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify The Center for Relationship and Sexual Health (CRSH) in writing of any changes in my account information or termination of this authorization prior to the next scheduled therapy session. In the case of a Transaction being declined, I understand that CRSH may, at its discretion, attempt to process the charge again within 30 days. If it is declined again, I agree to provide another means of payment prior to any further services provided by CRSH. I certify that I am an authorized user of this credit card/bank account and will not dispute these transactions with my bank or credit card company so long as the transactions correspond to the terms indicated in this authorization form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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248-399-7447

[www.crsh.com](http://www.crsh.com)

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