

ALLIED HYPNOSIS

ALLIED MENTAL HEALTH SERVICES

Client Information

Client: _____ Date : ____/____/____
Phone #: _____ SS#: _____ Gender: _____ DOB: ____/____/____
Address: _____ Apt#: _____ City: _____ ZIP: _____
Main Contact #: _____ Alt. Contact # (work): _____
Email: _____

Marital: _____ Edu: _____ Birthplace: _____ Occupation/Grade if student: _____
Number of Years at present address: _____ Employer or school: _____

Why are you here today?: _____

Seeking: Traditional talk therapy: ____ or Hypnosis/Hypnotherapy: ____

Current medications & dosage: _____

Date of Last Physical Exam: _____ Physician: _____ Phone #: _____

Previous Mental Health Treatment Experiences (Include dates, clinicians & outcome): _____

Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear about us? Personal Physician Radio Website Web Search
 Facebook/Twitter.

Please provide details (name, radio station personality, etc.): _____

For Adult Clients

If Married, How Long (years)? _____ Spouse's Employer: _____

If Divorced, When? _____ How Many Years Married? _____ Previous Name(s): _____

Please list all current and past family members treated for emotional or addiction problems (Family Member - Dates of Treatment - Problem(s) Treated):

Please list all family members who take drugs, including alcohol and prescription medicines in any amount or frequency (Family Member - Drug, Alcohol, Medication Taken - Amount Taken Daily (or weekend) - Dosage Level – Frequency):

For Child and Adolescent Clients

Who has Legal Custody of Client? _____ Relationship: _____

Date of Divorce if Applicable: ____/____/____ Custodian's Address & Phone # if Different than Client's:

Consent for Treatment:

ALLIED HYPNOSIS

ALLIED MENTAL HEALTH SERVICES

I, (print name) _____, give permission for treatment of the child over whom I have Legal Custody and the right to seek treatment on their behalf.

Signature of Legal Guardian: _____

All family members living with you:

1. _____ Relation: _____
DOB/Age: _____ Marital Status: _____ Edu: _____
Occupation/Grade if student: _____
2. _____ Relation: _____
DOB/Age: _____ Marital Status: _____ Edu: _____
Occupation/Grade if student: _____
3. _____ Relation: _____
DOB/Age: _____ Marital Status: _____ Edu: _____
Occupation/Grade if student: _____
4. _____ Relation: _____
DOB/Age: _____ Marital Status: _____ Edu: _____
Occupation/Grade if student: _____

Broken Appointment Policy

I understand that by making an appointment for professional services I am reserving time with a clinician that is exclusively my time. In the event I am unable to keep an appointment I will notify the office by phone at least one full business day before the appointment. I agree to pay Allied Hypnosis (a subsidiary of Allied Mental Health Services) the cost for the broken appointment (\$100) should I fail to keep the appointment. I agree to pay this cost at my next appointment or within 7 days of the broken appointment, whichever occurs first.

Client/Guardian (if client is a minor) Signature _____ Date: ___/___/___

Payment Agreement

At the time of service I agree to pay for all fees. I agree to make good on all payments whether by cash, personal check, debit card or credit card. I waive any claim or right to stop payment on personal checks or dispute any credit card or debit card charge once accepted for payment. Should the bank return my personal check for any reason, I agree to pay Allied Hypnosis that amount, plus \$25.00, in cash or by money order within 3 days of notification. Should my debit card or credit card deny payment for any reason, I agree to pay Allied Hypnosis that amount in cash or by money order within 3 days of notification. Further, I understand that any unpaid balance may be sent for collections or be reported to any of the three credit agencies according to state regulations.

Client/Guardian (if client is a minor) Signature: _____ Date: ___/___/___

Late Fees

I acknowledge that In the event an outstanding balance exists on my account Allied Hypnosis will send a statement by mail or email. My outstanding payment is due when statement is received. If no payment is received within 20 days of the dated letter, a \$20.00 late fee will be applied to my balance. I agree to pay this late fee unless I contact the office before the 20 days goes by and a mutual agreement is worked out. I further agree to pay an additional late fee of \$20.00 each month a balance remains on my account. Lastly, I agree to notify Allied Hypnosis of any changes to my mailing address, email address, or phone number.

Client/Guardian (if client is a minor) Signature: _____ Date: ___/___/___

Allied Mental Health Services
Allied Hypnosis
Client Contract and Guarantee of Service

I, _____, understand Allied Hypnosis (a subsidiary of Allied Mental Health Services) uses different types of hypnotherapy (direct, Ericksonian, Neuro-linguistic Programming) that are customized to each individual client according to his or her needs. I agree to be hypnotized so that my clinician can help me through setting specific goals and by giving me suggestions on how to achieve my goals and overcome the personal challenges I have chosen to work on while I am in a self-hypnotic state.

Suggestion is the artful use of imagination with a self-hypnotic state to increase a client's enthusiasm for self improvement and making good decision using self-help techniques. Self-help techniques are thinking strategies used by normally-functioning people to remind themselves of improvement they wish to make in their lives. Such strategies are taught by clinicians using suggestion while the client is in the self-hypnotic state. A common self-help technique is a regression. A regression is a review of significant or remarkable events by the client with the clinician serving as a guide.

The clinical staff of Allied Hypnosis may use these techniques to help clients regain self-control over alcohol, cigarettes, food intake, and stress; regain a positive mental attitude; restore self-confidence; improve sleep and sexual performance; reduce fears and worrying; and promote general wellness in their lives.

The staff of Allied Hypnosis are committed to helping me, as long as I follow their direction and comply with the assignments given to be done in between sessions. The clinical staff is more than willing to communicate with my medical doctors as long as I provide a signed release of information form which can be obtained through the Allied Hypnosis office. I understand that for me to succeed I will have to accept the responsibility of doing my part. Hypnotherapy is an active, participatory therapy and cannot succeed without my full commitment and complete cooperation. I am signing this agreement and beginning hypnotherapy because I am serious about accomplishing my goals as they were explained to my clinician.

According to top experts in the field of hypnosis and psychology (Milton Erickson, Richard Bandler, Dave Elman, and others) everyone with normal brain function and an imagination can be hypnotized. The vast majority of clients succeed in their goals quickly and with few sessions. However, for some who experience unusual difficulty and require additional sessions, our policies provide an incentive for clients not to give up. Because clients pay for a specific program, as opposed to a number of sessions which would typically cost more, there is no pressure to perform.

I agree to follow all suggestions given to me by the clinical staff of Allied Hypnosis, including keeping all scheduled appointments, homework assignments and lifestyle changes. I understand that if I don't keep appointments and follow all the instructions given me, Allied Hypnosis may choose not to continue working with me. I further agree to pay Allied Hypnosis \$100 for any and all broken appointments should I fail to provide at least a 24-hour notice of cancellation, unless the reason for canceling is an emergency situation. Clients arriving more than 20 minutes late for appointments are subject to the broken appointment fee, because that session will need to be rescheduled.

I understand that it is impossible to guarantee the behavior of another human being and that sometimes there may be psychological or medical issues involved. Although the clinical staff members of Allied Hypnosis are licensed and/or certified mental health providers, should psychotherapy sessions be required to resolve issues blocking hypnotherapy from working, I agree to participate in the psychotherapy either with my therapist, or with another licensed mental health provider of my choosing. I understand I would be financially responsible for the psychotherapy and that such additional fees are not part of the fees being paid for the hypnotherapy service. I further understand that refunds are only granted if the agreed upon hypnotherapy services are not performed due to the unavailability of the hypnotherapist and rescheduling appointments is not possible.

I have read, understand and agree to all the information contained in this contract.

Signature

Date

Allied Hypnosis is committed to your success. We guarantee the quality of our services and value the trust you have placed with us in helping you resolve the issues you want to change.