Amanda Gautreaux, MA
Rostered Psychotherapist
Hoping and Coping Counseling
139 Main St. Office #610
Brattleboro, VT 05301
HopingandCopingCounseling@protonmail.com
802-365-1751

New Client Information Form

Client First Name: LEILA

Client Last Name: FLANAGAN

Address (Street, town, zip code): 1241 TABER HILL RD. STOWE, VT 05672

Best Phone # (cell, home or work): (802) 793-8687

Email (for teletherapy as needed): Leilajosephine@icloud.com

May I contact you by phone and email: YES

Birth Date: 06/04/09

Age: 13

Social Security Number:

Primary Insurance Provider:

ID #:

Group #:

Co-pay:

Secondary Insurance Provider:

ID #:

Group #:

Co-pay:

Relationship to the Insured (Self/Spouse/Child):

Marital Status:

Employer:

Referral Source (Self/Doctor/Etc.):

Enrolled with Medicaid?

Enrolled with Medicare?

Do you have additional insurance?

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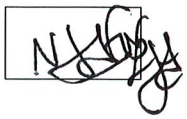
Informed Consent Documentation

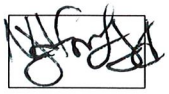
Please initial to the left of each item to acknowledge your understanding and agreement:


I have read this Informed Consent completely and have raised any questions I have with Amanda Gautreaux, MA (hereafter referred to as "Amanda"). I have received full and satisfactory response and agree to the provisions freely and without reservation.


I understand my responsibility for paying for services. If I am unable to keep a scheduled appointment, I understand that I must cancel by notifying Amanda Gautreaux at least 24 hours in advance. I understand that if I cancel a session within 24 hours prior to the appointment, I will be responsible for payment for the missed session, and that the cost for one clinical hour is $100.

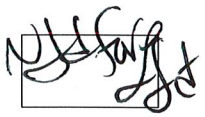

I understand the limits of confidentiality & the cancellation policy.

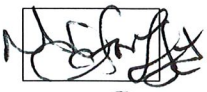

I understand that if we do teletherapy then Amanda will use my email or phone to send an invitation to teletherapy and that I am responsible for the security of any emails I send. Similarly, if I use an internet company such as Venmo for payment I understand that I am responsible for security of any internet transactions I initiate.

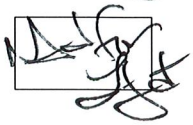

We have discussed issues involving teletherapy as described in this informed consent, including but not limited to a preemptive safety plan in the event of a mental health crisis.


I know how to make a complaint with Amanda if I am not satisfied with service.


I understand that I am a collaborator with Amanda and that we shall understand my problems and their solutions together as "co-researchers." While Amanda may have training and experience as a therapist, I understand that I am the expert regarding myself and that I will draw from the wisdom of my life to enrich our work.


I understand that Amanda meets with a therapist consultation group for her own professional betterment and to assist with client care. (This is routine for most clinicians to maintain licensure.) This consultation is strictly confidential. I understand that Amanda may wish to discuss my psychotherapy with the consultation group and that she will do so without specifically identifying me.


I have been offered a copy of this Informed Consent.


In the event of an emergency, I give Amanda permission to contact

Name	Phone	Relationship
NANCY duMont	(802)793-1430	Mother

Client Signature	Date	Parent/Guardian Signature	Date
		Nancy duMont	11/14/22

Client Signature	Date	Amanda Gautreaux, MA	Date