Life Guide Services

www.lifeguidetexas.com 2809 Regal Rd., Ste. 110
E-mail: sheaalexanderlpc@gmail.com Plano, Texas 75075

Group Participation Agreement

Please fill out the following information as completely and accurately as possible in order to help us better serve your needs. Use the back of the form if you need to give more info.

Name_____ Date of visit_____

Birth date: ____ /____ /____ Gender: ___ Male ___ Female ___ Other _____

Status: __Single __Married __Separated __Divorced __Widowed __ Living with a partner

__ Other (explain)_____ Driver's License #: _____ State: ___

Address: _____ City, State, and Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail(s): _____

Do we have permission to contact you (please check as many as you wish) at your:

__Work, __Home, __ Cell, __E-mail, __ Do not Contact me :(explain)_____

Occupation: _____ Current Employer: _____

Employment Length: ___ Part time ___Full time

Employer's Address: _____

__Home maker __ Out of work seeking employment __Other work: _____

__ Self employed, Type of business owned_____

Each group typically lasts 1.5 to 2 hours (depending on the type of group). Group leadership consists of one or two facilitators who are specialized and trained in the topic for which the group treatment is offered. To create a safe and positive environment for all group participants the following are required from all participants:

1) **Confidentiality.** Everything said within group, stays within the group setting. Exceptions to this rule are threats to harm oneself or another, disclosure of known or suspected abuse/neglect of a child, disabled or elderly person, court subpoenas for confidential information. When a subpoena is issued for information from your record, we may be required to release the requested information to the court.

2) **Respect.** Each member has the right to his/her own thoughts and feelings. It is important to maintain respect for others when expressing yourself.

3) **Consideration.** The group meeting is a time and space for everyone to share, it is important for each member to take responsibility to participate in the group discussion/activities or pass. Please refrain from monopolizing group's time, ask questions that are off topic and unrelated or engage in personal conversation with another group member while the meeting is in session.

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4) **Substance Use.** Please be aware that the use of alcohol and drugs (including prescription medications used improperly), can render group work ineffective. Therefore, should you choose to use such substances anytime on the day of group, we will be unable to meet with you in the group. In this case, please call to notify us of your intended absence (you will be charged for the group session in full — Insurance Companies do not cover canceled sessions).

5) **Attendance:** Your attendance and contribution is vital to group cohesion. However, we understand circumstance happen that may be beyond your control. If possible, please give at least a 24 hours advance notice of your intent to miss a group meeting. Absence from a meeting that is not due to an emergency or sudden illness will be charged at a full group rate. If you miss more than 2 group meetings, we may have to consider having you withdraw from the group, since it does not serve you and the group if you are not there and missing the discussions. If you have any questions or concerns about any of the above, please feel free to ask the group facilitators.

Health Insurance Information:

Do you receive mental health treatment benefits for group treatment? __No __Yes. If yes, are you planning to use your insurance for this provider's services? __No __Yes. If yes, Name of Insurance Company: _____ Type of Health Plan: _____

Insurance company's phone(s) for providers: _____

Policy/Insurance ID #: _____ Insurance Group #: _____

Name of Insured: _____ Relationship to the client: _____

Insured's Birth date: _____ Insured phone #: _____

Insured's Address: _____

Insured's Employer: _____ Employer's phone # and address: _____

_____

Mental Health benefits Deductible & Client's Co-pay: _____

Your signature below indicates that you understand and are in agreement with the group participation terms and are willing to participate in our group meeting:
Client's Signature: _____ Date: _____

Group Facilitator's Name & Credentials: _____

Group Facilitator's Signature: _____

Group Facilitator's Name & Credentials: _____

Group Facilitator's Signature: _____