



Confidential Counselling information sheet (kept on record)

FULL NAME ENTERING SESSIONS _____

D.O.B _____ **MALE** [] **FEMALE** [] **AGE** _____

FULL ADDRESS WITH POSTCODE _____

TELEPHONE NUMBER _____

MOBILE NUMBER _____

EMAIL ADDRESS _____

IN CASE OF MEDICAL EMERGENCY YOUR LOCAL GP MAY BE CONTACTED.

G.P NAME _____

ADDRESS _____

TELEPHONE _____

Notice to all clients: * Terms and conditions of payment

Payment will be required at the end of each session by BACS please. This is sent out via text or email. This is payable within 24 hours following the session time unless agreed otherwise.

48 hours' notice is required for cancellation of all appointments.

Pricelists are reviewed annually.

IS YOUR GP AWARE OF ANY CONCERNS?	YES	NO	(CIRCLE)
ARE THERE ANY OUTSIDE AGENCIES INVOLVED?	YES	NO	(CIRCLE)
ARE YOU/YOUR CHILD CURRENTLY TAKING ANY PRESCRIBED MEDICATIONS?	YES	NO	(CIRCLE)
HAVE YOU EVER HAD COUNSELLING BEFORE?	YES	NO	(CIRCLE)

SIGNED _____ **CLIENT ENTERING THERAPY. IF PARENT PLEASE TICK []**

FOR CHILD/STUDENT SESSIONS PLEASE FILL IN BELOW

SCHOOL/COLLEGE/UNIVERSITY ATTENDING: _____

SIGNED: _____ **PARENT/GUARDIAN OF UNDER 18-YEAR-OLD.**

PARENT/GUARDIAN CONTACT DETAILS IF DIFFERENT TO ABOVE/SECOND PARENT:

PHONE: _____ **EMAIL:** _____

**Becky Willoughby Founder Lead Counsellor at Willow. Practitioner Teacher.
Integrative Counsellor MBACP 064623 Family Counselling ASIIP Clinical Supervisor Dip.**



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Additional Family Members (for children and family sessions only)

1. FULL NAME _____ D.O.B _____ AGE _____

ADDRESS IF DIFFERENT _____

MOBILE _____ EMAIL _____

GP NAME _____ GP TELEPHONE _____

MEDICATION (IF RELEVANT) _____

OTHER AGENCIES (EG CAMHS, MENTAL HEALTH PROFESSIONALS, SS):

2. FULL NAME _____ D.O.B _____ AGE _____

ADDRESS IF DIFFERENT _____

MOBILE _____ EMAIL _____

GP NAME _____ GP TELEPHONE _____

MEDICATION (IF RELEVANT) _____

OTHER AGENCIES (EG CAMHS, MENTAL HEALTH PROFESSIONALS, SS):

3. FULL NAME _____ D.O.B _____ AGE _____

ADDRESS IF DIFFERENT _____

MOBILE _____ EMAIL _____

GP NAME _____ GP TELEPHONE _____

MEDICATION (IF RELEVANT) _____

OTHER AGENCIES (EG CAMHS, MENTAL HEALTH PROFESSIONALS, SS):

4. FULL NAME _____ D.O.B _____ AGE _____

ADDRESS IF DIFFERENT _____

MOBILE _____ EMAIL _____

GP NAME _____ GP TELEPHONE _____

MEDICATION (IF RELEVANT) _____

OTHER AGENCIES (EG CAMHS, MENTAL HEALTH PROFESSIONALS, SS):

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Terms and Conditions

CLIENT PLEASE RETAIN FOR YOUR RECORDS

All information is kept confidential in accordance with BACP code of ethics: British association of counselling and psychotherapy. For further information on counselling and for the Complaints procedure please refer to the BACP website: www.bacp.co.uk

- Please Note that 48 hours' notice is required for all cancellations or full fee will be required. This notice also applies to late cancellation due to sickness.
- It is the clients responsibility to remember appointment times set up with the counsellor. Willow does not accept responsibility for reminder messages.
- Payments can be made in cash or by BACS
- When seeing a designated Willow counsellor. Your initial assessment session is paid direct to willow. Details provided. all further sessions are paid directly to your counsellor. This is discussed at the initial meet.
- BACS payments are required within 24 hours of the session.
- When payment is to be made by BACS a text or email is sent out at the end of the working day. This message will contain the details of your fee to be paid and the account and sort code details.
- If payment is not received within 24 hours a gentle reminder message is sent out as standard procedure to remind clients.
- If BACS payments are consistently late, payment will be required before each session.
- Please note when making a BACS payment your account name will appear on our bank statement.
- For children's sessions parents are able to sit in the designated waiting room for the duration of the session if preferred. This facility is not available during the pandemic due to risk assessment.
- Childrens' sessions are designated to the child therefore Willow asks that no siblings are allowed to sit for the designated hour in the waiting room. This allows the child to feel at the centre of the process.
- For further information on child sessions please enquire.
- Parent sessions - we do at times offer sheets out to parents with valuable support. This is part of your session fee. If you would prefer a PDF format please specify to your counsellor and admin can forward this via email.
- Willow Therapy has a Facebook business page for professional practice, which you are welcome to follow. Please be aware that if you like or comment on this page your name will be visible.

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Signed agreement

CLIENT PLEASE RETAIN FOR YOUR RECORDS

If contacting Willow Therapy regarding any concerns, please use these numbers. Please call the number listed below regarding appointment changes.

Mobile contact for telephone and text: 07979814007 Becky Willoughby

Land line for telephone contact: 01442463939 Becky Willoughby

Email for contact and queries: becky@willow-therapy.com

Email for billing and invoice enquiries: admin@willow-therapy.com

Willow Therapy Tring

I have read and agree to abide by the terms and conditions of the agreement entered with willow therapy.

I agree to adhere to the cancellation policy and the payment policy of Willow Therapy Tring.

Parent/Guardian must sign if client is under 18. If you are a parent please tick { } I agree to sign on behalf of my child.

CLIENT:

PRINT NAME _____

SIGNED _____

DATE _____

COUNSELLOR ALLOCATED:

PRINT NAME _____

BACP NO _____

PHONE NO _____

SIGNED _____

DATE _____



Registered Member **64623**
MBACP

Signed agreement on entering therapy. 2 copies signed. 1 copy to be retained on record, 1 copy to be taken away with Terms and Conditions by client entering therapy. CLIENT COPY.

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WILLOW COPY (KEPT ON FILE)

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Email for contact and queries: becky@willow-therapy.com

Willow Therapy Tring

I have read and agree to abide by the terms and conditions of the agreement entered with willow therapy.

I agree to adhere to the cancellation policy and the payment policy of Willow Therapy Tring.

Who is funding sessions? _____ Email _____

Emergency contact number _____

Parent/Guardian must sign if client is under 18. If you are a parent please tick { } I agree to sign on behalf of my child.

CLIENT:

PRINT NAME _____

SIGNED _____

DATE _____

COUNSELLOR ALLOCATED:

PRINT NAME _____

BACP NO _____

PHONE NO _____

SIGNED _____

DATE _____



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MBACP

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