Abundance of Hope, LLC

Anna Maith, MEd., LGPC

Phone Number: 443-242-4098

E-mail: annamaith@abudanceofhopellc.com

Welcome

Welcome to Abundance of Hope! This form provides information about services offered. Please review it carefully and feel free to contact me with any questions. We are happy to assist you.

About my Services

Therapy has many potential benefits and may include improved personal and professional growth, stress management, relationships, grief, self-image, and mood. Clients will learn the importance of how to foster growth, heal, the difference between unhealthy vs healthy coping skills, effective communication, and work to create behavioral changes. Change can be difficult and there will be some discomfort which will be apart of the therapeutic process. Clients will collaborate with the therapist to address and navigate through any difficult and or painful memories. We will work as a team to create a holistic approach through evidence base practices to address your therapeutic goals.

Scheduling & Cancellation & Late Arrival

Scheduling an appointment is a commitment that both the therapist and client honor. There is a 15-minute grace period to arrive to the scheduled therapy session or it will be documented as a No Show which you will be responsible for the payment. All therapy sessions are scheduled by appointment. If you need to reschedule your appointment, please contact the office 24 hours prior to your appointment. If sessions are canceled or rescheduled with less than the required notice, or if a client misses a session, the client agrees to pay for the missed appointment. This fee is expected within 7 business days prior to your next session held. Please know that exceptions to this policy may be made in the event of a serious medical or family emergency.

Work Agreement

It is agreed that the client shall engage in the therapeutic process as a priority in her/his life. Suspension, termination, or referral shall be discussed between therapist and client for a pattern of behavior displaying disinterest, lack of communication, or for any unresolved conflict or impasse between therapist and client. Clients agree they will not hold me (Anna Maith, LGPC), nor my practice (Abundance of Hope, LLC), accountable in any way for possible injury.

Emergency Contact

The client will provide at least two emergency contacts, such as, the phone number and address of a family member, partner, or close friend. These emergency contacts may be used if I am unable to reach you and I perceive a need. I will also obtain alternative methods for contacting you, such as, cell and or work phone number. If you are in crisis and cannot reach me, please contact emergency services (911) or go to the nearest emergency room.

Service Fees

Anna Maith, Abundance of Hope, LLC is a Board Approved Licensed Graduate Professional Counselor by the State of Maryland. The charge for the first session

We, the therapist and client, have read and fully understand and agree to honor this agreement. We have also agreed to an initial definition of work and to the fee to be paid by the client.

Client Name (s)_____ Date: _____

Provider Name_____ Date: _____

Intake Date: _____

Demographic Information

Client First Name _____ Last Name _____

Address:

_____

City: _____ State: _____ Zip: _____

Social Security #: _____ Birthdate: _____

Age: _____ Gender: ____ F _____M Race/Ethnicity: _____

Phone #s: (C) _____ (W) _____ (H) _____

Email Address: _____

Presenting Difficulties/ Challenges:

_____
_____
_____
_____
_____
_____

Full Name of Guardian/ Spouse: _____

Phone #s: (C) _____ (W) _____ (H) _____

Address: _____

City: _____ State: _____ Zip: _____

Person responsible for payment: _____

Social Security #: _____

Signature of Person Responsible for Payment: _____

(Must be signed for services to begin)

Emergency Information

In case of an emergency, contact:

Full Name: _____ Relationship: _____

Phone #s: (C) _____ (W) _____ (H) _____

Address:

_____

City: _____ State: _____ Zip: _____

Full Name: _____ Relationship: _____

Phone #s: (C) _____ (W) _____ (H) _____

Address:

_____

City: _____ State: _____ Zip: _____

Physician Name: _____ Phone #: _____

Address:

_____

City: _____ State: _____ Zip: _____

Psychiatrist Name: _____ Phone #: _____

Address:

_____

City: _____ State: _____ Zip:

_____

Current Medication (s):

_____

_____

Allergies:

_____