Afterglow
BEHAVIORAL & SEXUAL HEALTH
Education Consultation Therapy

Dear Client,

Welcome to Afterglow Behavioral & Sexual Health — we're honored that you've chosen to begin your journey toward growth, healing, and connection with us. At Afterglow, we believe that emotional and sexual wellness are not separate parts of who you are — they are beautifully intertwined aspects of a whole, thriving self.

Our practice was founded on the idea that **everyone deserves to experience fulfillment, pleasure, and confidence** in both mind and body. Whether you're here for individual therapy, couples work, sexual health consultation, or training, our goal is to create a space where you can explore, learn, and heal at your own pace, with compassion and respect.

Our Approach

At Afterglow, therapy is more than just talking — it's a collaborative process rooted in empathy, education, and evidence-based care. We approach each person with curiosity and openness, integrating behavioral health principles with sex-positive and body-affirming care. You are the expert on your own experience, and we're here to guide and support you as you rediscover balance and confidence.

What to Expect

Your intake session is an opportunity for us to get to know you, understand your goals, and begin designing a plan that aligns with your needs. Throughout your time with us, we'll invite you to explore your story — including the ways your mind, body, and relationships interact.

We know that beginning therapy can feel both exciting and vulnerable. Please be assured that every member of our team is dedicated to creating a safe, confidential, and inclusive environment for you. We value authenticity, diversity, and the courage it takes to start this process.

Getting Started

Included in this welcome packet are a few important forms to complete before your first session. These forms help us understand your background, ensure confidentiality, and outline our shared expectations for care.
If you have any questions as you complete them, please don't hesitate to contact us — we're happy to help.

Thank you for trusting us to walk alongside you. We look forward to helping you rediscover your **Afterglow** — that sense of clarity, connection, and confidence that comes from embracing your whole self.

Warm regards,

Dr. R. Kent, LCSW-S, CST
Founder, Afterglow Behavioral & Sexual Health

www.afterglowhealth.com
dr.kent.sexhealth@gmail.com

Intake Documents For
Afterglow Behavioral & Sexual Health

SECTION 1: CLIENT INFORMATION

Date: _____

Full Name: _____

Preferred Name/Nickname: _____

Date of Birth: ____ / ____ / _____ **Age:** _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Other: _____

Pronouns: _____ **Sexual Orientation:** _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Email Address: _____

☐ OK to leave voicemail ☐ OK to send email ☐ OK to text

Emergency Contact Name: _____

Relationship: _____

Phone: _____

SECTION 2: RELATIONSHIP / COUPLES INFORMATION

(Complete only if attending as a couple or discussing relationship concerns)

Partner's Name: _____

Partner's Date of Birth: ____ / ____ / _____

Partner's Gender Identity/Pronouns: _____

Relationship Status: ☐ Married ☐ Partnered ☐ Dating ☐ Other: _____

Length of Relationship: _____

Primary Concerns in the Relationship:

SECTION 3: REFERRAL INFORMATION

How did you hear about Afterglow Behavioral & Sexual Health?

☐ Website ☐ Social Media ☐ Referral ☐ Friend/Family ☐ Other: _____

Referred by (if applicable): _____

SECTION 4: PAYMENT INFORMATION

Afterglow Behavioral & Sexual Health operates as a **self-pay private practice**.
Detailed information regarding session rates, payment methods, and financial policies is provided in the **Payment Overview document** included in this intake package.

Please review that document carefully before signing and submitting your intake forms.

SECTION 5: PRESENTING CONCERNS

Please describe the main reason(s) you are seeking therapy today:

When did these concerns begin? _____

Have they worsened recently? ☐ Yes ☐ No

What goals would you like to accomplish through therapy?

SECTION 6: BEHAVIORAL & MENTAL HEALTH HISTORY

Have you previously participated in therapy? ☐ Yes ☐ No

If yes, when and for what reason? _____

Was it helpful? ☐ Yes ☐ No

Do you currently take psychiatric medication? ☐ Yes ☐ No

If yes, list medication(s): _____

Do you have any current medical conditions? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever been hospitalized for mental health reasons? ☐ Yes ☐ No

If yes, please explain: _____

Previous and Current Mental Health Diagnoses:

Please list any past or current mental health diagnoses (e.g., depression, anxiety, PTSD, bipolar disorder, ADHD, etc.):

Any history of suicidal thoughts or self-harm? ☐ Yes ☐ No

If yes, please describe: _____

SECTION 7: SEXUAL HEALTH HISTORY

(All responses are confidential and used only to support therapeutic care.)

Are you currently sexually active? ☐ Yes ☐ No

Are your sexual relationships satisfying? ☐ Yes ☐ No ☐ Sometimes

Do you experience difficulty with:

☐ Desire/libido ☐ Arousal ☐ Orgasm ☐ Pain ☐ Communication ☐ Intimacy

☐ Trust ☐ Other _____

Have you ever experienced sexual trauma or coercion? ☐ Yes ☐ No

(If yes, please note that you may discuss this at your own pace during sessions.)

Do you have concerns about pornography use, sexual performance, or orientation?

SECTION 8: MEDICAL HISTORY

List all current medications:

List all known allergies:

Primary Care Physician: _____

Phone: _____

SECTION 9: TELEHEALTH CONSENT (Upheal Platform)

I understand that therapy sessions may be conducted via **Upheal**, a secure, HIPAA-compliant telehealth platform.

- I confirm that I am in a private location during sessions.
- I understand potential risks such as technical interruptions or unauthorized access, though safeguards are in place.
- I consent to receive care through telehealth when applicable.

Client Signature: _____ **Date:** _____

SECTION 10: INFORMED CONSENT FOR TREATMENT

I understand that therapy involves exploring personal and sensitive topics, which may cause discomfort. I acknowledge that I can withdraw consent at any time. I understand confidentiality limits as required by law, including:

- Suspected abuse of children, elders, or vulnerable adults
- Threats of harm to self or others
- Court orders requiring disclosure

I acknowledge that all records are confidential and comply with **HIPAA regulations**.

Client Signature: _____ **Date:** _____
Therapist Signature: _____ **Date:** _____

SECTION 11: RELEASE OF INFORMATION (Optional)

I authorize Afterglow Behavioral & Sexual Health to exchange information with:
Name/Organization: _____
Phone: _____
Fax/Email: _____
Purpose: ☐ Coordination of Care ☐ Referral ☐ Other: _____

Client Signature: _____ **Date:** _____

SECTION 12: CANCELLATION & PAYMENT POLICY ACKNOWLEDGMENT

- Cancellations require 24-hour notice.
- Late cancellations or no-shows may incur a full session fee.
- Payment is due at the time of service.

Client Initials: _____ Date: _____

SECTION 13: CLINICIAN USE ONLY

☐ Intake Completed ☐ Consent Signed ☐ Telehealth Verified

Notes: _____

Clinician Signature: _____ Date: _____

Clinical Resident and Supervisee Services Notice
Afterglow Behavioral and Sexual Health

Purpose of This Notice
At Afterglow Behavioral and Sexual Health, some therapy services are provided by **Clinical Residents** or **Supervisees in Social Work**. This document explains what that means, the nature of their licensure, how supervision works, and what you can expect as a client.

What Is a Clinical Resident or Supervisee?
A **Clinical Resident** or **Supervisee in Social Work** is a professional who has completed the required graduate education in counseling or social work and is now completing **post-graduate clinical experience** toward full independent licensure in the state.
They are qualified and authorized by the state to provide clinical services **under the supervision of a fully licensed clinician**. During this residency or supervision period, they engage in therapy, assessment, education, and treatment planning with clients under professional oversight.

What Is Residency and Supervision?
Residency and **Supervision** are structured learning and professional development processes designed to ensure quality care, clinical competence, and ethical practice.

- **Residency** refers to the period during which a therapist gains additional supervised clinical experience after earning a master's degree.
- **Supervision** is the process in which a **Licensed Clinical Supervisor** regularly reviews cases, provides feedback, and supports the resident or supervisee's professional growth.

Supervisors meet with residents weekly to review clinical work, documentation, treatment planning, and ethical considerations. Supervisors do **not** typically attend sessions, but they are available for consultation and oversight.

Licensure and Authority
Residents and supervisees hold a **limited or provisional license** issued by the state licensing board (e.g., Board of Social Work or Board of Counseling). This means:

- They **meet all educational and ethical standards** to practice under supervision.
- They **cannot yet practice independently** without supervision.
- Their clinical work is **monitored, guided, and reviewed** by a fully licensed clinician.

The supervisor is legally and ethically responsible for overseeing the quality of care provided and ensuring client safety.

Client Rights and Protections
You have the right to:

1. **Know the credentials** of your therapist and the name of their supervisor.
2. **Request to speak** with the supervisor if you have concerns about your therapy or services.

3. **Expect confidentiality**—your privacy is always protected. Supervisors may review session notes and recordings *only* for training and quality assurance, and always in compliance with HIPAA standards.
4. **Receive the same quality of care** you would from any licensed clinician.
5. **Decline or transfer services** if you prefer to work with a fully licensed provider (subject to clinician availability).

Supervisor Information
Resident/Supervisee Name: _____

Professional Title: _____

Supervisor Name: _____

Supervisor License Type/Number: _____

Supervisor Contact (through Afterglow): _____

Acknowledgment and Consent
I acknowledge that I have read and understood this information regarding services provided by a Clinical Resident or Supervisee in Social Work under supervision. I understand that my therapist holds a limited state license and is practicing under supervision as part of their post-graduate clinical requirements.
I understand that my confidentiality is maintained at all times and that supervision is for professional development and quality assurance purposes.

Client Name: _____

Client Signature: _____ **Date:** _____

Therapist Name: _____

Therapist Signature: _____ **Date:** _____

Afterglow Behavioral and Sexual Health
All clinicians, residents, and supervisees at Afterglow Behavioral and Sexual Health are committed to providing ethical, competent, and compassionate care under the guidance and standards of their respective state licensing boards.

Outcome Measures Assessment
Afterglow Behavioral & Sexual Health

(PHQ-9 • GAD-7 • Columbia Suicide Severity Rating Scale)
Client Name: _____

Date: _____

Clinician: _____

Session Type: ☐ Intake ☐ Follow-Up ☐ Discharge

INSTRUCTIONS
This assessment helps track emotional wellbeing and overall progress in therapy. Please answer each question as honestly as possible based on how you've felt **over the past two weeks.**

I. PHQ-9: Patient Health Questionnaire – Depression
Over the last two weeks, how often have you been bothered by any of the following problems?

	Question	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1	Little interest or pleasure in doing things	☐	☐	☐	☐
2	Feeling down, depressed, or hopeless	☐	☐	☐	☐
3	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4	Feeling tired or having little energy	☐	☐	☐	☐
5	Poor appetite or overeating	☐	☐	☐	☐
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7	Trouble concentrating on things, such as reading or watching television	☐	☐	☐	☐
8	Moving or speaking so slowly that other people could have noticed, or being so fidgety or restless that you've been moving more than usual	☐	☐	☐	☐
9	Thoughts that you would be better off dead, or of hurting yourself	☐	☐	☐	☐

Total Score: _____ **Severity:**
0–4 = Minimal 5–9 = Mild 10–14 = Moderate 15–19 = Moderately Severe 20–27 = Severe

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II. GAD-7: Generalized Anxiety Disorder Scale
Over the last two weeks, how often have you been bothered by the following problems?

	Question	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1	Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2	Not being able to stop or control worrying	☐	☐	☐	☐
3	Worrying too much about different things	☐	☐	☐	☐
4	Trouble relaxing	☐	☐	☐	☐
5	Being so restless that it's hard to sit still	☐	☐	☐	☐
6	Becoming easily annoyed or irritable	☐	☐	☐	☐
7	Feeling afraid as if something awful might happen	☐	☐	☐	☐

Total Score: _____ Severity:
0–4 = Minimal 5–9 = Mild 10–14 = Moderate 15–21 = Severe

III. Columbia Suicide Severity Rating Scale (C-SSRS) – Screen Version
Please answer the following questions about the past month.

	Question	Yes	No
1	Have you wished you were dead or wished you could go to sleep and not wake up?	☐	☐
2	Have you actually had any thoughts of killing yourself?	☐	☐
3	If yes to #2, have you been thinking about how you might do this?	☐	☐
4	Have you had these thoughts and had some intention of acting on them?	☐	☐
5	Have you started to work out or prepared to do anything to end your life?	☐	☐

If "Yes" to any of the above, ask:

	Question	Yes	No
6	Have you ever done anything, started to do anything, or prepared to do anything to end your life? (If yes, ask: When?)	☐	☐

Describe any affirmative responses and current safety concerns:

Clinician Risk Assessment:
☐ Low ☐ Moderate ☐ High **Safety Plan Initiated:** ☐ Yes ☐ No

IV. CLINICIAN REVIEW

Measure	Total Score	Severity	Date Reviewed	Clinician Initials
PHQ-9	_____	_____	_____	_____
GAD-7	_____	_____	_____	_____
C-SSRS	_____	_____	_____	_____

Clinical Notes / Next Steps:

AFTERGLOW HEALTH NOTICE

These outcome measures are used as part of your ongoing care and may be reviewed periodically to track progress and guide treatment planning. If you ever experience active thoughts of self-harm or suicide, please contact **988 (Suicide & Crisis Lifeline)** or go to the nearest emergency department.

Afterglow Behavioral and Sexual Health
Drug and Alcohol Assessment Form
Confidential Behavioral Health Record

Client Name: _____

Date of Birth: _____

Date of Assessment: _____

Clinician Name: _____

I. Presenting Concerns

1. Has anyone told you, or do you feel you have an issue with substance abuse?

   _____

2. Are your concerns related to alcohol, prescription medication, recreational drugs, or other substances?
   - ☐ Alcohol
   - ☐ Prescription medication
   - ☐ Recreational drugs
   - ☐ Other: _____

II. Substance Use History

Substance	Never	Past	Current	Age of First Use	Frequency (Daily, Weekly, Monthly)	Amount Used	Last Use Date	Primary Route (Oral, Inhaled, Injected, Smoked, etc.)
Alcohol	☐	☐	☐					
Cannabis	☐	☐	☐					
Cocaine/Crack	☐	☐	☐					
Opioids (Heroin, Pain Pills)	☐	☐	☐					
Methamphetamine	☐	☐	☐					
Hallucinogens (LSD, MDMA, etc.)	☐	☐	☐					
Benzodiazepines	☐	☐	☐					

Prescription Medications (non-prescribed)	☐	☐	☐					
Other Substances	☐	☐	☐					

III. Pattern and Context of Use

- Typical time(s) of day you use: _____
- Do you usually use alone or with others? _____
- Are there specific triggers, environments, or emotions that increase your use?

  _____

- Have you noticed tolerance (needing more to achieve the same effect)? ☐ Yes ☐ No
- Have you experienced withdrawal symptoms? ☐ Yes ☐ No

  If yes, describe: _____

IV. Consequences of Use

Have you experienced any of the following as a result of your use?

☐ Legal issues (DUIs, arrests)
☐ Financial difficulties
☐ Relationship strain
☐ Job or academic problems
☐ Health complications
☐ Risky sexual behavior
☐ Loss of control or memory blackouts
☐ Depression or anxiety related to substance use
☐ Other: _____

V. Treatment History

- Have you ever received treatment for substance use? ☐ Yes ☐ No

  If yes, provide details:

  - **Facility/Program Name:** _____
  - **Dates of Treatment:** _____
  - **Type of Program:** ☐ Inpatient ☐ Outpatient ☐ Detox ☐ Support Group
  - **Outcome:** _____

- Have you participated in peer support (AA, NA, SMART Recovery, etc.)? ☐ Yes ☐ No

  If yes, which group(s)? _____

VI. Co-Occurring Mental Health Concerns

- Have you ever been diagnosed with a mental health condition? ☐ Yes ☐ No

  If yes, specify: _____

- Do you experience mood swings, depression, anxiety, or trauma symptoms when using or withdrawing?

  ☐ Yes ☐ No If yes, describe: _____

- Any suicidal thoughts or behaviors (past or present)? ☐ Yes ☐ No

  If yes, please elaborate: _____

VII. Medical and Sexual Health Impact

- Any known medical conditions affected by substance use?

  _____

- Current medications: _____
- Have you noticed any impact on sexual desire, function, or satisfaction?

  ☐ Yes ☐ No

  If yes, describe: _____

VIII. Family and Social History

- Any family history of substance use or addiction? ☐ Yes ☐ No

  If yes, please describe: _____

- Who currently provides you with emotional or social support?

  _____

- How has your substance use affected your family, partner, or children?

  _____

IX. Readiness for Change

On a scale of 1–10, how motivated are you to reduce or stop your substance use?
(1 = Not ready, 10 = Completely ready)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What would be your biggest reasons for making a change?

_____

What support do you think would help you most?

☐ Individual therapy
☐ Group therapy
☐ Couples/family therapy
☐ Medication support
☐ Peer/recovery support
☐ Other: _____

Afterglow Behavioral and Sexual Health Informed Consent for Behavioral and Sexual Health Services

(Including Sex Therapy, HIPAA Compliance, and Telehealth via Upheal)

Provider: Dr. Ryan Kent
Practice: Afterglow Behavioral and Sexual Health

Email: dr.kent.sexhealth@gmail.com
Website: afterglowhealth.org

I. Purpose and Nature of Services

Welcome to Afterglow Behavioral and Sexual Health. Our mission is to provide compassionate, evidence-based behavioral and sexual health services that promote emotional wellness, sexual confidence, and healthy relationships.
Services may include:

- Individual therapy
- Couples/relationship therapy
- Sex therapy and psychosexual education
- Behavioral health and trauma-informed interventions
- Consultation and coaching
- Telehealth sessions provided through the secure **Upheal** platform

Therapy involves exploring personal topics that may evoke strong emotions or discomfort. The goal is to support insight, growth, and healthier functioning. Participation is voluntary, and you may withdraw consent at any time.

II. Confidentiality and HIPAA Compliance

Your privacy is a fundamental priority. Afterglow Behavioral and Sexual Health complies with all federal and state laws, including the **Health Insurance Portability and Accountability Act (HIPAA)**.
Your records, notes, and identifying information are stored in secure, encrypted systems that meet HIPAA standards.
Confidentiality is maintained except under the following circumstances required by law:

1. **Risk of harm:** If there is imminent danger to yourself or others.
2. **Abuse or neglect:** If there is suspected abuse or neglect of a child, elder, or dependent adult.
3. **Court order:** If records are subpoenaed by a court of law.
4. **Medical emergency:** When necessary to protect life or prevent serious injury.

No information will be released without your **written authorization**, except as noted above.

III. Nature of Sex Therapy Services

Sex therapy is a form of psychotherapy that addresses concerns related to sexual function, behavior, and intimacy. It is **strictly talk-based**; no physical or sexual contact occurs between therapist and client under any circumstances.
Sex therapy may address:

- Sexual desire or arousal difficulties
- Pain or discomfort during sexual activity
- Erectile or orgasmic challenges
- Relationship communication and intimacy
- Sexual trauma recovery
- Gender identity, orientation, or body image exploration

You are encouraged to discuss any questions or concerns openly at any point in treatment. If therapy ever feels uncomfortable or unclear, please communicate this with your therapist.

IV. Risks and Benefits

Therapy may involve discussing distressing topics, which can bring temporary discomfort or emotional intensity. However, therapy often leads to increased insight, improved coping, and stronger relationships.
Potential benefits include:

- Enhanced sexual and emotional satisfaction
- Improved communication and intimacy
- Greater self-understanding and confidence
- Reduction in anxiety, shame, or distress

No outcome can be guaranteed, and success depends on your participation, effort, and external factors both known and unknown.

V. Professional Boundaries

Afterglow Behavioral and Sexual Health adheres to ethical standards established by the **American Association of Sexuality Educators, Counselors, and Therapists (AASECT)**, the **National Association of Social Workers (NASW)**, and state licensing boards.
Professional boundaries are maintained at all times. Dual relationships (friendship, business, or romantic involvement between therapist and client) are not permitted during or after treatment.

VI. Fees, Payment, and Cancellation

- All fees are discussed and agreed upon prior to treatment.
- Payment is due at the time of each session unless alternate arrangements have been made.
- Cancellations require **24-hour notice** to avoid a late cancellation fee.
- Missed sessions without notice may be charged at the full session rate.

VII. Telehealth Informed Consent (Upheal Platform)

Telehealth services through **Upheal** allow you to engage in therapy remotely via a secure, HIPAA-compliant platform.
By agreeing to telehealth, you acknowledge the following:

1. **Technology and Security**
    - Sessions will be conducted using **Upheal**, a HIPAA-compliant telehealth platform.
    - Upheal employs end-to-end encryption to protect your privacy.
    - Despite best efforts, no electronic communication can be guaranteed to be fully secure.
2. **Confidentiality**
    - The same standards of confidentiality apply to telehealth sessions as to in-person therapy.
    - You are responsible for ensuring privacy on your end (e.g., conducting sessions in a private space).
3. **Location**
    - You must be physically located in a state where your therapist is licensed during each session.
4. **Emergency Protocols**
    - Before each telehealth session, you agree to provide your current physical address and an emergency contact.
    - In case of a disconnection during crisis or emergency, your therapist may contact you or your emergency contact directly.
5. **Limitations**
    - Telehealth may not be suitable for all cases, such as those involving acute crisis, suicidality, or severe dissociation.
    - Your therapist may recommend in-person sessions or referrals if telehealth becomes clinically inappropriate.

You have the right to withdraw consent for telehealth services at any time.

VIII. Communication and Record Keeping

Administrative communication (e.g., scheduling, billing) may occur via phone or secure email. Clinical discussions will not occur through text or social media.
Records are maintained electronically in a HIPAA-compliant system. You may request access to your records as permitted by law. A written request may be required.

IX. Emergencies and Crisis Resources

Afterglow Behavioral and Sexual Health does not provide 24-hour crisis coverage.
If you experience a crisis or emergency, please:

- Call **911** or go to your nearest emergency department, or
- Call the **988 Suicide and Crisis Lifeline**, or
- Contact your local crisis hotline, or
- If you are a veteran, call **988 and press 1** for the **Veterans Crisis Line**.

X. Client Rights

You have the right to:

- Receive services free from discrimination or bias.
- Be treated with respect and dignity.
- Ask questions about your treatment or records.
- Refuse or discontinue services at any time.
- Expect confidentiality within legal limits.
- Request referrals or second opinions.

XI. Consent and Acknowledgment

By signing below, I acknowledge that I:

- Have read and fully understand this informed consent document.
- Have had the opportunity to ask questions about behavioral health, sex therapy, and telehealth services.
- Understand the limits of confidentiality and the use of **Upheal** for telehealth sessions.
- Voluntarily consent to participate in therapy services with **Afterglow Behavioral and Sexual Health**.

Client Name: _____

Signature: _____

Date: _____

Therapist Name: _____

Therapist Signature: _____

Date: _____

Afterglow Behavioral and Sexual Health
Payment Overview and Authorization Form

Client Name: _____

Date of Birth: _____

Today's Date: _____

Payment Policy Overview
Afterglow Behavioral and Sexual Health is a private, fee-for-service practice. All professional services are **due and payable at the time of service**.

Afterglow Behavioral and Sexual Health uses **Square** as its secure payment processing system. A valid **credit or debit card is required to be kept on file** through Square's encrypted and PCI-compliant platform.

Your card will be **automatically charged at the time of each session** for the agreed-upon service fee.

If a payment is **declined for any reason**, a new, valid card must be provided **before any further therapy or coaching services can be rendered**.

Payment Procedures

- All services must be paid in full at the time of service.
- A valid credit or debit card must remain on file for the duration of services.
- Receipts for payment are available upon request.
- Square accepts most major credit cards (Visa, MasterCard, American Express, Discover).

Payment Schedule
Therapy services are provided in **30-, 45-, 60-, and 90-minute increments**, billed as follows:

Service Type	30 Minutes	45 Minutes	60 Minutes	90 Minutes
Individual	$100	$125	$150	$225
Couples (2 people)	$125	$150	$175	$250
Non-Monogamous Couples (more than 2 people)	$150	$175	$200	$275

Fees may be adjusted based on service type, specialty sessions, or extended consultations. Clients will be notified in advance of any rate changes.

Cancellation and No-Show Policy
Your appointment time is reserved specifically for you.
A **minimum of 24 hours' notice** is required to cancel or reschedule an appointment.

- **Cancellations made less than 24 hours in advance:** You will be charged **a late cancellation fee** equal to **50% of the session rate.**
- **No-shows or missed appointments without notice:** You will be charged **the full session fee.**

These charges will be automatically billed to the **card on file.**

Credit Card Authorization

I authorize **Afterglow Behavioral and Sexual Health** to securely store my credit card information through **Square's encrypted payment system** and to automatically charge my card for the following purposes:

1. **Payment for all scheduled therapy, coaching, or education sessions at the time of service.**
2. **Payment of late cancellation or no-show fees** as described above.
3. **Payment for collateral or professional services** rendered outside of scheduled sessions, including but not limited to: report writing, correspondence, consultations, and other requested services (billed in 15-minute increments).

I understand that:

- My card information will be stored securely in compliance with PCI-DSS standards.
- My card will be charged automatically at the time of service.
- If my card is declined, I must provide a new valid payment method prior to receiving additional services.
- Charges will appear on my statement as **Afterglow Behavioral and Sexual Health.**
- I may revoke this authorization in writing at any time, provided all outstanding balances are paid in full.

Credit Card on File (to be securely stored in Square):

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Name on Card: _____

Last 4 Digits of Card #: _____

Expiration Date (MM/YY): _____

Billing Zip Code: _____

Authorization and Acknowledgment

I have read and understand the payment policies of Afterglow Behavioral and Sexual Health. I agree that my card will be securely stored and automatically charged at the time of service, and that I am responsible for full payment of all fees, including no-show and cancellation fees.

Client/Responsible Party Signature: _____
Date: _____

Clinician Signature: _____
Date: _____