INFORMED CONSENT

SOME THINGS YOU SHOULD KNOW ABOUT COUNSELING

Before we start counseling together there are some things that you should know about the counseling process and about our office. In legal terms, this is called "Informed Consent." This information will help you understand better what to expect, and it will explain some limitations about what you and your clinician will be doing.

Your Privacy and Confidentiality

Of course, all of our work together – our conversations, your records, and any information that you give us – is protected by something called legal *privilege*. That means that in most cases the law protects you from having information about you given to anyone without your knowledge and permission. Our office respects your privacy, and we intend to honor your *privilege*. However, the law also makes some important exceptions to your privacy.

If we believe there is a risk you might harm yourself or someone else, we may be required to contact the authorities to give them the opportunity to protect you. If you are abusing children, an elderly person, or a disabled adult, we must notify the authorities, so they can protect others from harm. Also, if you become involved in any lawsuit in which your mental health is an issue – for example, a custody dispute or an injury lawsuit in which you claim compensation for emotional pain and suffering – then the court or the lawyers may insist upon, and may obtain your information from us. Similarly, you would lose the protection of your privilege if you file a complaint against us with the state licensing board or if you sue us.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third-party payer, our office must share certain information with them, including (but not necessarily limited to) your diagnosis and the times of your visits. If there is a managed care company, they may require us to provide additional information, such as your symptoms and your progress. You should also understand that insurance and managed care information is often stored in national computer databases. By your signature, below, you authorize our office to provide information to your insurance and managed care companies to the extent necessary for them to pay for your services. If we find ourselves in a dispute with you over billing, our office may provide a collection service any information necessary to clarify and to collect an outstanding balance.

Side effects of counseling and other potential unpleasantness

You should know that counseling is not always easy. You may find yourself having to discuss personal information. You could find those conversations difficult and embarrassing, and you might be very anxious during and after such conversations. As you learn more about yourself, you might encounter increased conflict with friends, co-workers, and family members. It is possible that you might become somewhat depressed. Counseling is intended to alleviate those problems, but sometimes at first, as you get to the root of some things, you may feel them even more acutely than in the past. We may also ask you to do some things that might, at first, make you feel uncomfortable or awkward. Sometimes counseling requires trying new and unfamiliar ways of doing things. You will always be free to move at your own pace, however. We will work with you to make changes, but we cannot promise anything about the results you will obtain. The outcome you achieve will depend on many things.

Our office specializes in individual/couples/family psychotherapy and psychological assessments. If we believe that your problem requires knowledge that we do not have, we may refer you for a consultation with someone with specific training or experience. We will discuss any such referral with you before we act. At the very beginning we will create a treatment plan with you. That is, we will look at what you would like to change, what we will do to change it, how we will know you are succeeding, and how long it will take. Every now and again, we will review that plan to see if it needs to be updated.

Our office policies

Therapy sessions usually last 45 to 60 minutes, and we must end each session promptly. Payment is due at the time of your appointment. We can accept cash, checks, or credit cards for your payment. Our office will charge a $80 fee if you are late, or if you cannot make your appointment and you do not cancel the appointment at least twenty-four hours in advance. Your insurance will not pay for missed sessions; you must pay for those, yourself. Our office charges a $30 fee for any check returned for any reason.

Our telephone is only answered during business hours. Through the day, we check messages regularly, and whenever possible we try to return phone calls the same day; however, phone calls after 3 p.m. will be returned by the next business day. If we have not returned your call within twenty-four hours, please try again as your message may have been lost. If you have an emergency after that time, call 911, or go to an emergency room and ask them to contact us.

When we are out of the office for several days, the messages you leave may be answered by another clinician. We will probably not have discussed your case with that person, but he or she will make every effort to be helpful to you in our absence.

Your clinician will meet with you on a regular basis, usually every week or two weeks. You will be charged for any appointments that you miss if you do not call our office at least 24 hours in advance of the appointment. If you miss a scheduled visit, it is your responsibility to call the office to schedule another appointment if you wish to continue your counseling effort. After a missed appointment, if you do not call our office within ten days to reschedule, your clinician will accept that as your notice that you have terminated counseling with our office and that you wish to have no further services from our office.

After hours telephone calls may be accepted. There is no charge for a phone call that lasts ten minutes or less. For telephone consultations that require more than ten minutes, our office charges $30.00 for each fifteen-minute increment or any part of a fifteen-minute increment. Both of these fees are due and payable when they are incurred but must be paid by the time of your next scheduled visit; insurance does not ordinarily pay for telephone consultations. There may be times when you want your clinician to read documents that will help with understanding you and your needs. If reading such documents requires more than fifteen minutes, your clinician will bill you for that time, fees that your insurance company, generally, will not pay.

Other charges may apply: If you, or someone else (for example, another clinician or your lawyer), needs a copy of your file or of other records that may be legally necessary, our office charges a reasonable fee for copying, plus postage. If our office is required to provide a verbal report, for example by telephone to your physician, a ten-minute consultation will not be charged. If the consultation exceeds ten minutes, our office charges $150 per hour; that fee is billed in fifteen-minute increments for each quarter hour or part of a quarter hour. If our office must produce a

written report, the same fee will be billed for the time spent reviewing your file and drafting and publishing the report.

Other Office Policies

Our clinicians are not allowed to accept gifts from patients. While we appreciate your thoughtfulness, we are prohibited by the canons of our profession from accepting gifts from our patients.

Similarly, our professional practice standards prohibit our clinicians from accepting requests to connect or to be "Friends" on internet sites such as Face Book, LinkedIn, Twitter, and other electronic and social media.

By your signature below you authorize our office to designate an appropriate professional to serve as custodian of your record, and who will assume possession of, and responsibility for your treatment record in the event of your clinician 's death or disability. In that event notice will be posted, as necessary, on your clinician 's web page and telephone voice mail.

Your Treatment

Type of Treatment requested and planned: _____

Your clinician 's customary Fee is: $150 per session. _____

Your Copay (if you are using a third party payer) is: _____ per session

By your signature below you consent to the treatment offered herein, you agree to pay for your counseling services as indicated and at the time of service, and if you are using a third party (e.g. insurance) payer, you agree that our office may provide any information to your insurance carrier and managed care company necessary to consider, process, and approve payment of services. Further, you agree that all charges are, finally, your responsibility, and that in the event your insurance carrier refuses payment, you agree to pay all amounts due. Your clinician may refuse to schedule an appointment until you have paid any outstanding balance you have with our office. If you are unable to pay for your services in the future, you understand and agree that your clinician will be unable to continue services. In that event, your clinician will provide you with a referral to another provider more readily able to work within your budget.

_____	_____	_____
Patient Signature	Date	Clinician Signature

Jo Ann Travis Evans Counseling
Compassion • Courage • Conversation

Credit Card Authorization

Card Holder Name: _____

Billing Address: _____

_____

Credit Card Number: _____

Expiration Date: _____ Security Code (3-digit): _____

Amount to Charge: $80 Late fee and/or _____ for each session (USD)

I authorize Jo Ann Travis Evans Counseling to charge the agreed amount listed above to my credit card provided herein. I agree that Jo Ann Travis Evans Counseling may charge an $80 fee for missed or canceled appointments without 24-hour notice. I agree Jo Ann Evans, LMFT may charge the agreed amount listed above for each session. I agree that I will pay for this service in accordance with the issuing bank cardholder agreement.

_____ _____

Cardholder Printed Name Cardholder's Signature

_____ Date

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Authorization to Obtain, Release, and Exchange Clinical Information

Completing and signing this form will allow Jo Ann Travis Evans Counseling to obtain, release, and exchange privileged, confidential, and protected information from your clinical record(s) to and/or from the person or entity you designate below.

Patient's Printed Name: _____ Date of Birth: _____

My signature below authorizes Jo Ann Travis Evans Counseling to obtain, release, and exchange clinical information to and/or from:

Name: _____
Address: _____
_____
_____
Telephone: _____
Fax: _____
Email: _____

I want Jo Ann Travis Evans Counseling to obtain, release, and/or exchange the following clinical information (as indicated by checkmarks below) contained within my patient/treatment/office records:

- ☐ Appointment dates
- ☐ Clinical interview information
- ☐ Progress/Therapy/Case notes
- ☐ Psychological assessment/test results
- ☐ Other: _____
- ☐ Psychological testing/assessment raw data (e.g., protocols, transcripts, worksheets, etc.)
- ☐ Any written opinions regarding the referral Question addressed in a psychological evaluation
- ☐ treatment planning / recommendations

This authorization will remain in effect until _____ or for 12 months from the date of signing, whichever is sooner.

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to Jo Ann Travis Evans Counseling office address. I further understand that my revocation will not be effective to the extent that Jo Ann Travis Evans Counseling has taken action in reliance upon this signed authorization.

_____ _____
Patient or Guardian's Signature Date

_____ _____
Witness Signature Date

Demographic Questionnaire

A. Identification

Your legal name: _____ Date of birth: ____/____/____

Other names you have used (maiden, nicknames, aliases): Address: _____

_____ City: _____

State: _____ Zip: _____

Home phone number: _____

Work number:_____

Email: _____

_____

Driver's license #: _____ ☐Other ID #: _____ State: _____

Disability status: _____ ☐Talk about later

Gender identity: _____ ☐Talk about later

Sexual orientation: _____ ☐Talk about later

Racial/ethnic identities: _____ ☐Talk about later

Religious/spiritual traditions or identity: _____ ☐Talk about later

Other ways you identify yourself and consider important: _____

B. Emergency information

If some kind of emergency arises and we cannot reach you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

C. Referral

Who gave you my name to call? Name: _____

Address: _____ Phone: _____

How did this person explain how I might be of help to you? _____

Is this person's relationship with you ☐personal or ☐professional?

If professional, may I let this person know that you have come to see me? ☐Yes ☐No

D. Current problems or difficulties

Please describe the main difficulties that led to your coming to see me: _____

When did these problems start? _____

_____

What makes these problems worse? _____

_____

What makes these problems better? _____

_____

With therapy, how long do you think it will take for these to get a lot better? _____

E. Your medical care

From whom, or where, do you get your medical care? Clinic/doctor's name: _____

_____

Address: _____ Phone: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed, and we can coordinate your treatment? ☐Yes ☐No

What current medical or mental health diagnoses do you have?

_____

Rate your general level of health: ☐Excellent ☐Good ☐Fair ☐Poor ☐Extremely poor

Current medications	For what condition?	Prescribed and supervised by:

F. Your education and training

How many years of school have you had (including elementary and high school)? __ years

Degrees/certificates: _____ Field(s) of study: _____

G. Employment and military experiences

Current occupation: ____ Current employer: _____

_____

Date hired: _____/_____/ _____

Address: _____

City: _____ State: _____ Zip: _____

Previous employment history

From (date)	To (date)	Name of employer	Job title or duties	Reason for leaving

Have you been in the military? ☐No ☐Yes: From: _____ to: _____ Highest rank held? _____

H. Family-of-origin history

1. Members of your family as you grew up

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Parent/Guardian 1					
Parent/Guardian 2					
Stepparents					
Brothers					
Sisters					

If you were adopted or raised by other than your biological parents, how old were you when this started?

_____

_____

Briefly describe your relationship with your brothers and/or sisters: _____

_____

Which of the following best describes the family in which you grew up? ☐ Warm/accepting ☐ Average ☐ Hostile/Fighting

2. Parent/Guardian 1 Name: _____ Please describe this caregiver: ___

_____

How did this person discipline you? _____

How did this person reward you? _____

How much time did this person spend with you when you were a child? ☐A lot ☐Average ☐Little

How did you get along with this person when you were a child? ☐Poorly ☐Average ☐Well

How do you get along with this person now? ☐Poorly ☐Average ☐Well ☐Does not apply

Did this person have any problems (e.g., alcoholism, violence) that may have affected your childhood development?

☐ Yes ☐No ☐Don't know

Is or was there anything unusual about this relationship? ☐No ☐Yes: _____

3. Parent/Guardian 2 Name: _____ Please describe this caregiver: ___

_____

How did this person discipline you? _____ How did this person reward you? _____

How much time did this person spend with you when you were a child? ☐A lot ☐Average ☐Little

How did you get along with this person when you were a child? ☐Poorly ☐Average ☐Well

How do you get along with this person now? ☐Poorly ☐Average ☐Well ☐Does not apply

Did this person have any problems (e.g., alcoholism, violence) that may have affected your childhood development?

☐ Yes ☐No ☐Don't know

Is or was there anything unusual about this relationship? ☐No ☐Yes: _____

I. Marital/couple relationship history

	Spouse's/partner's name	His/her age at marriage	Your age at marriage	Your age when divorced/widowed	Has he/she remarried?
First					
Second					

J. Children

In the last column below, indicate those from your current marriage with "Y," those from a previous marriage or relationship with "P," and your current stepchildren with "S.")

Name	Current age	Sex	School	Grade	Adjustment problems?	Yours? Previous? Step?

K. Religious concerns

What role, if any, does faith or spirituality play in your life? _____

_____

What is your present religious affiliation, if any? _____

L. Other

Is there anything else that is important for me to know about, and that you have not written about on any of these forms?

☐ No ☐ Yes, and I have written about it on another sheet of paper.

Please add additional information here: