REVELATIONS
COUNSELING & CONSULTING

Joanne L. Strawder, LCSW
305 Hanson Avenue, Suite 170
Fredericksburg, Virginia 22401
Phone: 540.361.4330 | Fax: (540) 361-4331

PSYCHOTHERAPY INFORMED CONSENT DOCUMENT

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

My Responsibilities to You as Your Therapist

I. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member or your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you, but I ask that as a professional courtesy, you notify me at least 24 hours in advance.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality.

If you elect to communicate with me by email or text messaging at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email message I receive from you, and any responses that I send to you, will be kept in a secure file.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services (CPS) within 48 hours and Adult Protective Services immediately. If you are between the ages of 16 and 18 and you tell me that you are having sex with someone more than 5 years older than you, or sex with a teacher or a coach, I must also report this to CPS, even though at age 16 you have the right to consent to sex with someone no more than 5 years older than you. I would inform you before I took this action.

3. If I believe that you are in imminent danger or harming yourself, I will explore all options to ensure that you are willing to take the necessary steps to ensure your safety. If you are unable or unwilling to guarantee your safety, I will legally break confidentiality and call the Police, your significant other, or your parent/legal guardian if you are a minor under the age of 18 years. I am obligated to do this, and would explore all other options with you before I took this step.

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in couples therapy.

If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be part of the couples therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything you wish kept secret from your partner. I will remind you of this policy before beginning such individual session.

II. Record keeping

I keep very brief records. All of your initial documentation will be maintained in your file, and your case notes will be maintained using an electronic software program. Case notes will simply identify that you attended the session, your mental status at the time of the session, what interventions happened in session, and what your response was. Your records are confidential and maintained in a secure location that cannot be accessed by anyone else. Should you require information maintained in your confidential records, I would be happy to provide you with a summary of the services that have been provided and your subsequent responses.

III. Diagnosis

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be reimbursed for services. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If you have questions about your diagnosis I will discuss it with you. All of

the diagnoses come from a book titled the DSM V. I have a copy in my office and will be glad to let you use it to learn more about what it says about your diagnosis.

IV. Other Rights

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decide to do what I'm doing, and to look at alternatives that might work better. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

V. Managed Mental Health Care

If your therapy is being paid for in full or in part by a managed care company, there are usually further limitations to your rights as a client imposed by the contract of the managed care company. These may include their decision to limit the number of sessions, the amount of time allowed for each session, or the period of time within which you must complete your therapy.

My Training and Approach to Therapy

I have a Master's Degree in Social Work earned in 2000 at Virginia Commonwealth University, and I am licensed as a Clinical Social Worker in the state of Virginia. In my practice I use Cognitive Behavioral Therapy (CBT). CBT is a psychotherapeutic approach that addresses dysfunctional emotions, maladaptive behaviors and cognitive processes and contents through a number of goal-oriented, explicit systematic procedures. CBT is problem focused and action oriented.

Your Responsibilities as a Therapy Client

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last between 30-60 minutes. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than 24 hours notice, you must pay for that session at our next scheduled meeting. I cannot bill these session to your insurance. The answering machine has a time and date stamp which will keep track of the time that you called me to cancel. The only exception to this rule about cancellation is if you would endanger yourself by attempting to come (due to bad weather conditions that would affect your ability to drive), or if you or someone whose caregiver you are has fallen ill suddenly.

You are responsible for paying for your copayment, deductible, or co-insurance at the time the session is conducted, unless we have made other firm arrangements in advance. I accept cash and checks.

Encounter and Fee for Professional Service

Initial Evaluation	CPT Code 90791	$120.00
Individual Therapy	CPT Codes 90832, 90834, 90837	$120.00
Family/Cojoint Therapy with client present	CPT Code 90847	$120.00
No show/Late Cancel of less than 24 hours	Not covered by insurance	$60.00
Report or consultation with a third party	Not covered by insurance	$60.00
Attendance at a meeting	Not covered by insurance	$500.00
Subpoena to appear in court	Not covered by insurance	$1000.00

Emergency phone calls are included. However, if we spend more than 10 minutes in a week on the phone, if you leave more than ten minutes worth of phone messages in a week, or if I spend more than 10 minutes reading and responding to emails from you during a given week, I will bill you a prorated basis for that time.

If you have insurance, and would like for the administrative staff at Aquia Counseling & Therapy to submit your bill to your insurance company for reimbursement, you will need to provide your most current and updated insurance information to complete this process. If you have more than one insurance policies, you are responsible for identifying for Aquia Counseling & Therapy which insurance policy is the primary policy and which is the secondary policy. If you are not sure which policy is primary and which is secondary, our administrative staff will be happy to assist you. If by your omission or error, Aquia Counseling & Therapy bills your secondary insurance company, and is subsequently unable to obtain reimbursement for services from your primary insurance company, then you will be responsible for your bill in full. If you change insurance companies during the course of treatment, you are responsible for informing the administrative staff prior to your session. This ensures that the correct insurance company is billed and prevents you from paying for the session out of pocket. If you have questions about your insurance policies, the administrative staff will be happy to assist you.

Complaints

If you are unhappy with what's happening in therapy, I hope you will talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can complain about my behavior to the Virginia Board of Social Work, 9960 Maryland Drive, Suite 300, Henrico, Virginia 23233-1463

Client Consent to Psychotherapy

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the listed fees for services. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Joanne Strawder, LCSW. I know I can end therapy at any time I wish and that I can refuse any therapeutic suggestions made by Joanne Strawder, LCSW.

Printed Name(s): _____

_____

Rate for Services: $_____ per hour session

Signed: _____ Date: _____

Signed: _____ Date: _____

Witness Printed Name/Signature: _____

NEW CLIENT INTAKE

Joanne Strawder, LCSW

DATE: _____

REGISTRATION

CLIENT NAME: _____ GENDER: ☐ M ☐ F DATE OF BIRTH: _____
(Last, First, Middle Initial) (MM/DD/YYYY)

HOME ADDRESS: _____ City/State/Zipcode _____

HOME TELEPHONE: _____ LEAVE MESSAGES? ☐ YES ☐ NO

MOBILE TELEPHONE: _____ LEAVE MESSAGES? ☐ YES ☐ NO

ARE YOU CURRENTLY EMPLOYED? ☐ YES ☐ NO HOW LONG? _____

PLACE OF EMPLOYMENT: _____ POSITION: _____

IF YOU HAVE CHANGED JOBS IN THE LAST FIVE YEARS, GIVE DURATION OF EMPLOYMENT AND REASON FOR LEAVING:

_____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP TO YOU: _____

NAME OF PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____ PHONE: _____

PERSONAL BACKGROUND

RELATIONSHIP STATUS: ☐ Married ☐ Living Together ☐ Not Dating ☐ Divorce/Separated ☐ Widowed

(Check any that apply)

PARTNER/SPOUSE NAME: _____ DURATION OF RELATIONSHIP (Years) _____

CHILDREN (NAME, AGES AND EDUCATION STATUS): _____

_____

_____

CUSTODY STATUS (IF APPLICABLE) _____

LIST EVERYONE WHO LIVES IN YOUR RESIDENCE: _____

RELIGIOUS IDENTIFICATION (IF ANY): _____

MEDICAL AND MENTAL HEALTH HISTORY

REASON FOR APPOINTMENT AND WHAT YOU HOPE TO ACHIEVE WITH THERAPY: _____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

HAVE YOU EVER SOUGHT HELP FOR THIS PROBLEM BEFORE? ☐ YES ☐ NO

IF YES, WITH WHOM, AND FOR HOW LONG? _____

WHAT WAS HELPFUL ABOUT THIS COUNSELING? _____

_____

PRIOR HOSPITALIZATION(S) FOR EMOTIONAL, MENTAL HEALTH OR PSYCHIATRIC REASONS? ☐ YES ☐ NO

CURRENT HEALTH AND MEDICAL CONCERNS (Please describe): _____

CURRENT MEDICATIONS & DOSAGES: _____

_____

NEW CLIENT INTAKE

IF COUPLES THERAPY BOTH PARTNERS PLEASE COMPLETE THIS PAGE SEPARATELY

EARLY DEVELOPMENT & FAMILY

ANY SIGNIFICANT TRAUMA GROWING UP? ☐ YES ☐ NO

ANY COMPLICATIONS DURING MOTHER'S PREGNANCY/YOUR BIRTH? ☐ YES ☐ NO ☐ UNKNOWN

ANYTHING UNUSUAL ABOUT YOUR CHILDHOOD DEVELOPMENT? _____

IN RANK ORDER, OLDEST TO YOUNGEST, WHERE IS YOUR PLACE IN THE ORDER AMONG SIBLINGS? _____

HOW MANY BROTHERS AND SISTERS? BROTHERS _____ SISTERS _____

WHICH FAMILY MEMBERS OR OTHER RELATIONSHIPS ARE YOU CLOSE TO? _____

_____

WHICH FAMILY MEMBERS ARE A PROBLEM FOR YOU? _____

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR CHILDHOOD/ADOLESCENCE:

☐ Happy Childhood ☐ Major Depression/Suicide Attempts ☐ Victim of crime/emotional trauma

☐ Alcoholism/Drug Use ☐ Violence/Physical Abuse ☐ Sexual abuse

☐ Arrests/Convictions ☐ Emotional Abuse/Neglect ☐ Other:

EDUCATION HISTORY

☐ High School: Years Completed _____ ☐ College: Years Completed _____

ANY DIAGNOSED LEARNING OR SPEECH DISABILITIES? ☐ YES ☐ NO

ANY HISTORY OF ATTENTION DEFICIT OR BEHAVIOR PROBLEMS IN SCHOOL? ☐ YES ☐ NO

MENTAL AND PHYSICAL HEALTH ASSESSMENT

ON A SCALE OF 1 - 5, HOW WOULD YOU RATE YOUR CURRENT HEALTH? _____

Please review the following areas and circle the level of severity the problem may be causing for you:
Scale: 0 = No Problem, 5 = Disabling Problem

0 1 2 3 4 5	**Sleep too much**	0 1 2 3 4 5	**Nightmares**
0 1 2 3 4 5	**Sleep too little**	0 1 2 3 4 5	**Overwhelming fears**
0 1 2 3 4 5	**Interrupted sleep**	0 1 2 3 4 5	**Racing thoughts**
0 1 2 3 4 5	**Other sleep problems**	0 1 2 3 4 5	**Feelings of sadness**
0 1 2 3 4 5	**Memory**	0 1 2 3 4 5	**Thoughts of harming someone else**
0 1 2 3 4 5	**Concentration**	0 1 2 3 4 5	**Walking in sleep**
0 1 2 3 4 5	**Loss of interest in usual activities**	0 1 2 3 4 5	**Attention**
0 1 2 3 4 5	**Thoughts of suicide**	0 1 2 3 4 5	**Unable to relax**
0 1 2 3 4 5	**Loss of energy**	0 1 2 3 4 5	**Blackouts**
0 1 2 3 4 5	**Feeling tired all the time**	0 1 2 3 4 5	**Excessive sweating**
0 1 2 3 4 5	**Periods of crying**	0 1 2 3 4 5	**Death of family members or friends**
0 1 2 3 4 5	**Feeling of hopelessness**	0 1 2 3 4 5	**Panic attacks**
0 1 2 3 4 5	**Loss of sexual desire**	0 1 2 3 4 5	**Mood swings**
0 1 2 3 4 5	**Outbursts of anger**	0 1 2 3 4 5	**Spending sprees**
0 1 2 3 4 5	**Change in appetite**	0 1 2 3 4 5	**Changes in energy level**
0 1 2 3 4 5	**Unable to recall periods of time in childhood after age 5**	0 1 2 3 4 5	**Hearing voices when no person is present**
0 1 2 3 4 5	**Unable to recall some period of your day**	0 1 2 3 4 5	**Thoughts that some person or people are trying to harm you**
0 1 2 3 4 5	**Thoughts that won't go away that are constantly in your head**	0 1 2 3 4 5	**Noticing items in your home and not knowing where they came from or how they got there**
0 1 2 3 4 5	**Feelings of being controlled by forces outside yourself**	0 1 2 3 4 5	**Feeling compelled to repeat activities for no reason**