REVELATIONS
COUNSELING & CONSULTING

James Kasten, LPC, NCC
282 Choptank Road, Suite 103
Stafford, Virginia 22556
Office: 540.602.2545 | Fax: 540.602.2542

PSYCHOTHERAPY INFORMED CONSENT DOCUMENT

Welcome, it takes courage to reach out for support and we look forward to supporting your healing journey. These forms contain information about James Kasten's professional counseling services and business policies. It is important that you review the following information before beginning your first session. Please feel free to ask any questions you may have about these policies; James will be happy to discuss them with you

Psychotherapy Services
Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. However, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This relationship helps to foster 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, and the goal is *your* well-being. There are, however, certain limitations to those rights that are summarized for your awareness in this document. As a therapist, I also have corresponding responsibilities to you as *your* therapist.

My Responsibilities to You as Your Therapist

My responsibilities to you as a client include your rights to confidentiality, proper disposition of your treatment records, protection of personally identifiable information and personal health information, and the provision of services within my scope of training and appropriate to your diagnosis.

Confidentiality
With the exception of specific situations that are described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what we discuss, 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 of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always

act to protect your privacy even if you provide your written consent 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 courtesy and to prepare accordingly, that 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 ensures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (e.g., sending bills or faxing information), it will be done with special safeguards to ensure your 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. I do not return email messages with clients. All emails are retained in the repositories of our respective internet service providers. While under normal circumstances no one reviews these repositories, they are technically available to be read by the system administrator(s) of the internet service provider. Any email or text message I receive from you, and any responses that I send to you, will be kept secure on a password-protected device. You should also know that any emails received from you and any responses that sent to you could become a part of your legal and medical record**.**

The following are legal exceptions to your right to confidentiality. I would inform you in advance of any situation 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 take this action.

3. If I believe that you are in imminent danger of harm or for 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 must legally and ethically break confidentiality and call the police, your spouse, adult emergency point of contact, 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 action.

Record keeping

My case notes will generally identify that you attended the session, your mental health status at the time of the session, interventions that may have been applied in session, and your progress towards your goals. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file.

You have the right to request that I correct any errors in your file. You also have the right to request that I make a copy of your file available to another health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else. In conjoint therapy (couple or family therapy), you will share one joint medical record. In order to release information from your joint record, your therapist will need permission from all adult parties.

Diagnosis

If a third party such as an insurance company is a payor for your billed services, I am generally required to conduct biopsychosocial assessments and provide a diagnosis to the third party in order to file claims for payment. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term issues. If you have questions about your diagnosis, I will discuss it with you. All of the diagnoses I determine will come from a book titled the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. 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.

Social Media Policy

As a matter of policy, I do not accept friend requests, contact requests, nor do I follow back from current or former clients on social networking sites (e.g., Facebook, Twitter, Instagram, LinkedIn). I believe that adding clients as friends constitutes a dual-relationship, while also jeopardizing your confidentiality and privacy. For this same reason, I ask that clients do not attempt to communicate with me through any interactive media or social networking websites. If there are things from your online life that you wish to share with me, please bring them into your sessions, where we can view and explore them together, during the therapy hour.

Couple and Family Therapy

Please note that with couples and family therapy the couple and/or the family is the client (e.g. the treatment unit), **not the individuals**. I practice a **no-secrets policy** when conducting couple or family therapy. This means that confidentiality does not apply between the couple or among family members when one member of the treatment unit requests an individual session or contacts me outside of the therapy session to share a secret. On occasion an individual session may be scheduled to assist in the overall therapy process to the treatment unit (e.g. the couple) and will be scheduled only when mutually agreed upon. Please understand that any information given in the individual sessions **will not** be held in confidence or secret in couples and/or family sessions.

I will encourage the person holding the secret to share the secret in the following session and will support the client in doing so. I also reserve the right to share or disclose information revealed by one partner or family member in an individual session to the other partner or family members as deemed appropriate or necessary to support the treatment unit's overall treatment progress and goals. Should a partner or family member be unwilling to reveal confidences, conjoint therapy may then be contra-indicated. I may then need to terminate treatment and provide you with a more appropriate referral.

Your Responsibilities as a Therapy Client

Appointments

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last between 30-60 minutes. The time scheduled for your appointment is assigned to you and you alone. When you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice by calling the Revelations front office staff at (540) 602-2545. 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 sessions 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.

Ongoing Cancellations or Multiple No-Shows

It is understandable that occasionally an appointment will be cancelled or missed due to illness or emergency. However, your regular session day/time has been reserved for you. My current client schedule and wait list does not allow for a great deal of flexibility with respect to continual cancellations, rescheduled appointments, or no shows. If you find that your schedule is no longer able to accommodate the session time reserved for you, please discuss this with me. I will do my very best to find an alternative solution, such as telemedicine sessions, so that we can continue our work together. However, please note that should ongoing cancellations, frequent reschedules (even those within the same week), missed appointments, late payments/nonpayment become an issue, I will discuss this with you. If after discussing other options with you your attendance has not changed, we will need to open up your reserved time to the waitlist and add you to the waitlist. If you prefer not to be placed on the waitlist, then we will provide you with three therapy referrals and/or terminate with you. If you no-show for two (2) sessions in a row and do not respond to further correspondence, I will assume that you have chosen to discontinue therapy.

Rates for Services

My encounter rates for professional services are summarized as follows:

Professional Service	CPT Code	Time	Fees
Initial Evaluation	90791	60 minutes	$150
Individual Therapy	90837	60 minutes	$125
Individual Therapy	90834	45 minutes	$110
Individual Therapy	90832	30 minutes	$90
No show/Late Cancel of less than 24 hours	Not covered by insurance	N/A	$60
Letter/Report to a Third Party	Not covered by insurance	N/A	$100
Attendance at a Meeting Outside of Office	Not covered by insurance	N/A	$200
Subpoena to Appear in Court	Not covered by insurance	N/A	$1000

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.

If you have insurance and would like for the administrative staff at Revelations Counseling & Consulting 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 Revelations Counseling & Consulting 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, Revelations Counseling & Consulting 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.

Correspondence
I am able to take brief phone calls or answer a short email between sessions. 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.

Emergency Procedures
I am not an emergency or crisis provider. If you are having a mental health crisis or emergency, please call 911 or go to your nearest emergency room. After you have been seen by the emergency room staff, please call the Revelations front office staff at (540) 602-2545.

Complaints
If you are not satisfied with our work together, please talk with me about it in our sessions so that we can address these concerns together. I take these concerns seriously. If you believe that I have been unwilling to listen or respond appropriately, or that I have behaved unethically, you can register a complaint to the Virginia Board of Counseling, 9960 Maryland Drive, Suite 300, Henrico, Virginia, 23233-1463.

Other Rights
You have the right to ask questions about anything that happens in therapy. It is always my intention to work collaboratively with you on your goals for therapy. 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 that I am not the right therapist for you. You are free to leave therapy at any time.

My Training and Approach to Therapy

I have completed my Master's Degree in Professional Counseling with Liberty University, and I am licensed as a Licensed Crofessional Counselor with the Board of Counseling in the Commonwealth of Virginia. I am also a Nationally Certified Counselor. My approach to therapy is collaborative, honest, challenging, and direct with solid boundaries and empathy. I reflect, assist, encourage, and point out incongruent patterns around actions and words. I will not work harder than my clients or accept responsibility for your choices or consequences. I respect my client's decisions, and do not advise or direct my clients, as I believe that you are the expert in your own life and are fully capable of creating the life that you want with support and tools. I use interventions from evidenced-based therapeutic modalities that include Cognitive Behavioral Therapy, Client-Centered Therapy, Existential Therapy, Narrative Therapy, Internal Family Systems Therapy, Emotionally-Focused Therapy, and Gottman Couples Therapy. You can find more information of these various therapy models at https://www.psychologytoday.com/us/types-of-therapy.

Client Consent to Psychotherapy

I have read this statement, have had sufficient time to be sure that I considered it carefully, asked any questions on points which required clarification, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in my treatment, and to release of that information and other information necessary for clinical consultation, as necessary. I also understand the rate I am being charged for services. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with James Kasten, LPC, NCC. I know I can end therapy at any time I wish, and that I can refuse any therapeutic recommendations provided by my therapist.

Printed Name(s): _____

_____

Rate for Services: **$_____ per hour session**

Signed: _____ **Date:** _____
Patient/Parent or Guardian

_____ **Date:** _____
Patient/Parent or Guardian

Witness Printed Name: _____

Signature: _____ **Date:** _____

NEW CLIENT INTAKE

James Kasten, LPC, NCC

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: _____

_____

ETHNICITY: ☐Asian ☐Black/African ☐Pacific Islander ☐Caucasian ☐Native American ☐Hispanic

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