REVELATIONS
COUNSELING & CONSULTING

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PSYCHOTHERAPY INFORMED CONSENT DOCUMENT

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.

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 must end on time so that we do not delay the next client's session. If you must reschedule a session, please notify me within 24 hours by calling the Revelations front office staff at (540) 602-2545, or leave a voicemail on my mobile number at (703) 888-7010.

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

Payments are made directly to "Revelations Counseling & Consulting", or "Guy Strawder, LMFT". I do offer sliding scale rates based on your current income status, or for services that may not covered by your health insurance. Upon request, we will establish this rate in our initial session together.

Emergency phone calls are included in your service rates. However, if we spend more than 10 minutes in a week on the phone, or if you leave more than ten minutes worth of phone messages in a week, I must document my services time responding to these calls, and our practice charges you on a prorated basis for that time. I am often not immediately available by telephone. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If you feel you cannot wait for my return call and you perceive it is an emergency situation, go to your local hospital or call 911.

If you miss a session without canceling, or if you cancel with less than a 24-hour notice, a no-show/late cancellation fee of $60 must be paid prior to our next scheduled appointment. If you need to cancel an appointment, please call the administration office at (540) 602-2545, or you may leave a voicemail on my mobile number at (703) 888-7010. Each of these contact points has a time and date-stamp to track the time that you call to cancel. The only exceptions to this 24-hour cancellation rule is if you would endanger yourself by attempting to come (e.g., due to bad weather conditions that would affect your ability to drive), or if you or someone that you are responsible for as a primary caregiver has suddenly become ill or injured. If you no-show for two (2) sessions in a row and do not respond to my attempt to reschedule, I will assume that you have chosen to discontinue therapy.

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.

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, Virginia Code § 37.2-400 and Administrative Code 12VAC35-115-80 ensure 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. 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.

Under the provisions of the 1996 HIPAA Standards for Privacy of Individually Identifiable Health Information (“Privacy Rule”), 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.

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, but 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.

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.

4. If a court or child protection worker orders a release of information.

5. **Couples Therapy.** This stipulation is not a legal exception to your confidentiality; however, it is a policy that I require if you are in couples therapy. If you and your partner decide to schedule 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 sessions.

6. **Parents and Minors.** While privacy in therapy is crucial to successful progress, parental involvement can also be essential. Parents are a vital part of therapy with a child and may be asked to actively participate during the session. For children 13 and older, standard practice includes the sharing of general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the minor child's agreement, unless I assess there is a safety concern. In this case, I will make every effort to notify the minor child of my intention to disclose information and address any objections.

7. **Adolescents.** Except for those situations listed in paragraph 6., I will not disclose to your parent or guardian specific things you share with me in our private therapy sessions. However, if you are engaging in risk-taking behavior, then I will use my professional judgment to decide whether you are

in serious or immediate danger of being harmed. If I assess that you are in such danger, I will first encourage you to share this information with your parents. Should you be unwilling to do so, I will communicate it to your parent or guardian directly.

Occasionally, I will also seek consultation with the co-principal of Revelations Counseling & Consulting, Mrs. Joanne Strawder, LCSW. Mrs. Strawder is my spouse and a licensed clinical social worker. I will seek your permission before seeking consultation, and will only share information that is necessary to help me conceptualize treatment plans for our therapeutic work together.

Record keeping

My case notes will generally identify my assessment of your mental health status at the time of the session, interventions that may have been applied in session, and progress towards your goals. You have the right to a copy of your file and 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.

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 Networking

As a matter of policy, I do not accept friend requests from current or former clients on social networking sites (e.g., Facebook, 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.

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 Marriage and Family Therapy with Liberty University, and I am licensed as a marriage and family therapist with the Board of Counseling in the Commonwealth of Virginia. Marriage and Family Therapy is founded upon systems theory which identifies how individual problems emerge from relational contexts, and then treats these problems through a collaborative and personalized process with each client. I apply systems theory and interventions for individual counseling to treat anxiety, depression, post-traumatic stress and addictions, and also to resolve relational problems in the counseling of families, couples and adolescents (13+ years and older). I generally rely upon interventions

from Emotionally-Focused Therapy, Bowenian Family Therapy, and Experiential Family Therapy, and I am a Gottman Level 1 Certified Couples Therapist. I also incorporate complementary interventions from Existential Therapy, Narrative Therapy, Cognitive Processing Therapy, and Rational-Emotive Behavioral Therapy (REBT). REBT is a focused and action-oriented psychotherapeutic approach that addresses rational thinking to facilitate intentional, productive behaviors leading to greater psychological resiliency.

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 Guy Strawder, LMFT. I know I can end therapy at any time I wish, and that I can refuse any therapeutic recommendations provided by my therapist.

Patient 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

GUY S. STRAWDER, LICENSED MARRIAGE & FAMILY THERAPIST

DATE:

REGISTRATION					
CLIENT NAME (Last, First, MI)		Biological Sex ☐ M ☐ F ☐ Other		Date of Birth (MM/DD/YYYY)	
HOME ADDRESS (including City/State/Zip Code)					
HOME TELEPHONE		Leave Messages	☐ Yes	☐ No	
MOBILE TELEPHONE		Leave Messages	☐ Yes	☐ No	
EMAIL ADDRESS					
ARE YOU CURRENTLY EMPLOYED?	☐ Yes ☐ No	HOW LONG?			
POSITION/PLACE OF EMPLOYMENT					
IF YOU HAVE CHANGED JOBS IN THE LAST FIVE YEARS, GIVE DURATION OF EMPLOYMENT AND REASON FOR LEAVING:					
EMERGENCY CONTACT	RELATIONSHIP TO YOU	TELEPHONE			
NAME PRIMARY CARE PHYSICIAN		TELEPHONE			
ADDRESS PRIMARY CARE PHYSICIAN					

PERSONAL BACKGROUND	
ETHNICITY	☐ Asian ☐ Black or African ☐ Hispanic or Latino ☐ Middle Eastern ☐ Native American or American Indian ☐ Pacific Islander ☐ White/European ☐ Other
RELATIONSHIP STATUS	☐ Married ☐ Not Married ☐ Living Together ☐ Divorced/Separated ☐ Widowed
RELIGIOUS IDENTIFICATION (IF ANY)	
PARTNER/SPOUSE NAME (Last, First, MI)	DURATION OF RELATIONSHIP (YEARS)

CHILDREN NAMES	AGE	EDUCATION STATUS
CUSTODY STATUS (If Applicable)		
LIST EVERYONE THAT LIVES IN YOUR HOUSEHOLD		

MEDICAL & MENTAL HEALTH HISTORY			
REASON FOR APPOINTMENT:			
HOW LONG HAVE YOU HAD THIS PROBLEM?		HAVE YOU SOUGHT HELP FOR THIS PROBLEM PREVIOUSLY? ☐ YES ☐NO	
IF YES, WITH WHOM, AND FOR HOW LONG?			
WHAT WAS HELPFUL ABOUT THIS THERAPY?			
ANY 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
DESCRIBE ANYTHING UNUSUAL ABOUT YOUR CHILDHOOD:			
IN RANK ORDER, OLDEST TO YOUNGEST, WHERE IS YOUR PLACE IN THE ORDER AMONG SIBLINGS?			
HOW MANY BROTHERS AND SISTERS IN YOUR FAMILY?	BROTHERS	SISTERS	
WHICH FAMILY MEMBERS OR OTHER RELATIONSHIPS ARE 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 Abuse	☐ Violence/Physical Abuse	☐ Sexual Abuse
☐ Arrests/Convictions	☐ Emotional Abuse/Neglect	☐ Other (Describe)

EDUCATION HISTORY			
HIGH SCHOOL YEARS COMPLETED:	COLLEGE YEARS COMPLETED:	DEGREE/SPECIALTY:	
ANY DIAGNOSED LEARNING OR SPEECH DISABILITIES?	☐ YES	☐ NO	
ANY HISTORY OF ATTENTION DEFICIT OR BEHAVIORAL PROBLEMS IN SCHOOL?	☐ YES	☐ NO	

MENTAL & PHYSICAL HEALTH ASSESSMENT	
ON A SCALE OF 1 – 10, WITH 10 BEING "BEST", HOW WOULD YOU RATE YOUR PHYSICAL 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	Noticing items in your home and not knowing where they came from	0	1	2	3	4	5	Thoughts that won't go away and are constantly in your head
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