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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

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 or cancel a session, please notify me within 24 hours by calling the Revelations front office staff at (540) 602-2545, or leave a voicemail. The practice voicemail 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 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 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.

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
Family/Cojoint Therapy with client present	90847	60 minutes	$120
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	$500
Subpoena to Appear in Court	Not covered by insurance	N/A	$1000

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 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.

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.

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. You are protected under the provisions of the 1996 Federal Health Insurance Portability and Accountability Act (HIPAA) which 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 through the office email, please be aware that email is not completely confidential. Please do not send urgent or emergency messages through email. 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.

In addition, 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 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 that another person

attend a therapy session with you and we can discuss the potential advantages and drawbacks, but I ask that, as a courtesy and to prepare accordingly, that you notify me of this wish at least 24 hours in advance.
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. 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 child's agreement, unless the therapist feels there is a safety concern (reference all aforementioned sections on Confidentiality for exceptions), in which case the therapist will make every effort to notify the child of his/her intention to disclose information ahead of time and make every effort to handle any objections that are raised.

7. **Adolescents.** Except for those situations listed above, 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 need to use my professional judgment to decide whether you are in serious or immediate danger of being harmed. If I feel 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. You should also know that, by law in Virginia, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.

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. 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 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 I determine will come from a book titled the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. I have a copy in the practice and will be glad to let you refer to 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 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.

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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 Joanne Strawder, LCSW. 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

Joanne Strawder, Licensed Clinical Social Worker

DATE: ______________________________

REGISTRATION

CLIENT NAME: ______________________ BIOLOGICAL SEX: ☐ 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

EMAIL ADDRESS: ______________________

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 ☐ Not Dating ☐ Living Together ☐ 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: ______________________

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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
- ☐ Alcoholism/Drug Use
- ☐ Arrests/Convictions
- ☐ Major Depression/Suicide Attempts
- ☐ Violence/Physical Abuse
- ☐ Emotional Abuse/Neglect
- ☐ Victim of crime/emotional trauma
- ☐ Sexual abuse
- ☐ 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

Rating	Area	Rating	Area
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