



**Hilary Towers, PhD, MS
Resident in Counseling**

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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 payment at the time of service and for coming to your session on time and at the time we have scheduled. Sessions last between 45-55 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 | Time | Fees |
|---|-------------|-------------|
| Individual Therapy | 55 minutes | \$75 |
| Couples/Family Therapy | 55 minutes | \$90 |
| Individual Therapy | 45 minutes | \$65 |
| No show/Late Cancel of less than 24 hours | N/A | \$60 |
| Letter/Report to a Third Party | N/A | \$50 |
| Attendance at a Meeting Outside of Office | N/A | \$100 |
| Subpoena to Appear in Court | N/A | \$1000 |

As a Resident in Counseling at Revelations Counseling & Consulting, I am under the supervision of Mr. Guy Strawder, LMFT. My rates are established by the practice site Chief, Clinical Services and payments are made directly to "Revelations Counseling & Consulting, LLC". In accordance with the Virginia Board of Counseling Regulations 18 VAC 115-50-10 et seq., I cannot bill your healthcare insurance provider. The

practice does permit me to offer sliding scale rates based on your current income status, and 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 will charge 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.

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 my clinical supervisor, Mr. Guy Strawder, LMFT, 282 Choptank Road, Suite 103, Stafford, Virginia 22556, or telephone (540) 602-2545, ext. 1007.

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.

As a Resident in Counseling, I must consult regularly with my clinical supervisor, Mr. Guy Strawder, LMFT, on client cases. The Virginia Board of Counseling requires a minimum of one hour and a maximum of four (4) hours of direct clinical supervision for every forty (40) hours of work experience during the period of my residency. Occasionally, I may also seek consultation with the Chief, Clinical Services of Revelations Counseling and Consulting, Mrs. Joanne Strawder, LCSW and other therapists that may specialize in particular topics relevant to your therapy. I will request your permission before seeking consultation other than from my clinical supervisor, and will only share information that is necessary to help me conceptualize treatment plans for our work together.

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

Under the terms of my residency, I am required to conduct biopsychosocial assessments and provide a diagnosis for every assigned client. Diagnoses are technical terms that describe the nature of mental health problems and details 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 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

As a Resident in Counseling, I have completed my Master's Degree in Clinical Mental Health Counseling from Divine Mercy University. My training includes work with children, adolescents, adults, and couples. My clinical interests include premarital counseling, marriage counseling, sex addictions, trauma-related care, depression, anxiety, and spousal abandonment. I am currently working toward certification in logotherapy, a clinical approach developed by psychiatrist and Holocaust survivor Viktor Frankl. I am a

certified facilitator of the Prepare/Enrich program, an evidence-based approach to marital preparation and enrichment. My primary treatment approaches are attachment-oriented, cognitive-behavioral, and existential, and I am trained for the optional integration of religious or spiritual considerations into my therapeutic approach.

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 Hilary Towers, MS, Clinical Mental Health Counseling, Resident in Counseling. 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: _____
Patient/Parent or Guardian

Date: _____

Patient/Parent or Guardian

Date: _____

Witness Printed Name: _____

Signature: _____

Date: _____

NEW CLIENT INTAKE FORM

| GENERAL INFORMATION | | |
|--|--|----------------------|
| Client Full Legal Name: | Date of Birth: | Date: |
| | | |
| Preferred Name: | Grade: (If Minor) | Gender: |
| | | |
| Home Address: | City & State: | Zip Code: |
| | | |
| Cell Phone: | Email Address: | |
| | | |
| <input type="checkbox"/> Preferred <input type="checkbox"/> Texts Okay <input type="checkbox"/> Voicemail Okay | <input type="checkbox"/> I would like to receive appointment reminders. | |
| Home Phone | Work Phone: | |
| | | |
| <input type="checkbox"/> Preferred <input type="checkbox"/> Texts Okay <input type="checkbox"/> Voicemail Ok | <input type="checkbox"/> Preferred <input type="checkbox"/> Texts okay <input type="checkbox"/> Voicemail Okay | |
| Current Marital Status: | | |
| <input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | |
| Length of Current Marriage/Separation: | Number of Marriages: | |
| | | |
| Spouse's Name: | Spouse's Number of Marriages | Date of Birth: |
| | | |
| Children's Names & Ages: | | |
| | | |
| Currently Living With (check all that apply): <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Parents <input type="checkbox"/> Other <input type="checkbox"/> Alone | | |
| Who were you referred by? | May I have permission to thank that person? | |
| | | |
| Emergency Contact: | Phone Number: | Relationship to You: |
| | | |

| CURRENT CONCERNS | |
|---|---|
| What concerns have led you to pursue counseling at this time? | |
| | |
| Please rate the severity of your present concerns on the following scale. Check One: | |
| <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Totally Incapacitating | |
| Where are your concerns causing the most problems? (Check all that apply) | |
| <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Marriage <input type="checkbox"/> Other Relationships <input type="checkbox"/> God | |
| How long have these difficulties been present? | |
| | |
| What do you hope to gain from counseling? | |
| | |
| Please Indicate which of the following areas are currently problems for you (check all that apply): | |
| <input type="checkbox"/> Under too much pressure/feeling stressed. <input type="checkbox"/> Excessive anxiety or worry <input type="checkbox"/> Feeling lonely <input type="checkbox"/> Angry feelings <input type="checkbox"/> Concerns about finances <input type="checkbox"/> Feeling "numb" or cut off from emotions <input type="checkbox"/> Angry outbursts <input type="checkbox"/> Excessive fear of specific places/objects <input type="checkbox"/> Difficulty making friends <input type="checkbox"/> Feeling as if you'd be better off dead <input type="checkbox"/> Feeling that people are "out to get you" <input type="checkbox"/> Feeling manipulated or controlled by others <input type="checkbox"/> Difficulty making decisions <input type="checkbox"/> Loss of interest in sexual relationships <input type="checkbox"/> Concerns about physical health <input type="checkbox"/> Insomnia (no sleep) or Hypersomnia (sleep all the time) | <input type="checkbox"/> Blackouts or temporary of loss of memory <input type="checkbox"/> Loss of appetite/increased appetite <input type="checkbox"/> Lacking self-confidence <input type="checkbox"/> Issues with food and/or weight <input type="checkbox"/> Abuse of alcohol and/or non-prescription drugs <input type="checkbox"/> Delusions <input type="checkbox"/> Feeling distant from God <input type="checkbox"/> Hallucinations <input type="checkbox"/> Inability to concentrate while at work/school <input type="checkbox"/> Crying spells <input type="checkbox"/> Nightmares <input type="checkbox"/> Obsessions or compulsions with specific activities <input type="checkbox"/> Inability to control thoughts <input type="checkbox"/> Feeling trapped in rooms/buildings <input type="checkbox"/> Hearing voices <input type="checkbox"/> Loss of interest in usual activities/lack of motivation |

| PREVIOUS MENTAL HEALTH TREATMENT | | | |
|----------------------------------|---------------------|---------------------------------|--------------|
| Dates: | Therapist/Facility: | Reasons for seeking counseling? | Did it help? |
| | | | |
| | | | |

| CURRENT PSYCHIATRIC MEDICATIONS | | | |
|---------------------------------|--------------|--------------------|---------------|
| Dates Used: | Name & Dose: | Reason Prescribed: | Does it help? |
| | | | |
| | | | |

Have you been given any mental health diagnoses from previous counselors? If yes, please list them.

| Have You | No | Yes | If yes, please describe. |
|---|--------------------------|--------------------------|--------------------------|
| Been hospitalized for mental health purposes? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Had suicidal thoughts or threats? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Had suicidal gestures and/or attempts? | <input type="checkbox"/> | <input type="checkbox"/> | |

| MEDICAL/HEALTH INFORMATION | | | |
|----------------------------|-------------|---------------|-------------|
| Primary Care Provider: | | Psychiatrist: | |
| | | | |
| Address: | | Address: | |
| | | | |
| Phone Number: | Fax Number: | Phone Number: | Fax Number: |
| | | | |

Please rate your overall health. Check one:
 Excellent Good Fair Poor

Medical Diagnoses/Health Concerns:

| CURRENT MEDICATIONS | | | |
|---------------------|--------------|--------------------|---------------|
| Dates Used: | Name & Dose: | Reason Prescribed: | Does it help? |
| | | | |
| | | | |

| PERSONAL & FAMILY HISTORY | | | |
|---|------|---------|---|
| Have you ever experienced any traumatic events (e.g. accident, death of loved one, combat)? If yes, please describe. <input type="checkbox"/> I prefer to discuss in session. | | | |
| | | | |
| Have you ever experienced physical, sexual, verbal, or emotional abuse, family violence, or neglect? If yes, please describe. <input type="checkbox"/> I prefer to discuss in session | | | |
| | | | |
| Is there a family history of mental health disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe | | | |
| | | | |
| Is there a family history of substance abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe. | | | |
| | | | |
| Is there a family history of suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe. | | | |
| | | | |
| How would you describe your childhood? | | | |
| | | | |
| How would you describe your current relationship with your parents? | | | |
| | | | |
| What was your birth order? _____ out of _____ | | | |
| Sibling's Name | Age: | Gender: | Please describe current relationship with each sibling. |
| | | | |
| | | | |
| | | | |
| | | | |
| Is there anything else about your family or family history that your counselor should know? | | | |
| | | | |

| EDUCATION | |
|---------------------------------------|---------------------------------|
| Highest Level of Education Completed: | Field of Study (if applicable): |
| | |

| EMPLOYMENT | |
|----------------------------|-------------------|
| Occupation: | Current Employer: |
| Current Work Difficulties: | |

| LEGAL |
|--|
| Have you had any legal trouble/involvement and/or involvement in lawsuits? If yes, please explain: |

| RELIGIOUS BACKGROUND (OPTIONAL) | |
|---|--|
| Do You Believe in God? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure |
| Religious Preference: | What house of worship do you currently attend? |
| How much influence does your religion have on your day-to-day activity? | |
| Are clergy providing you with pastoral support? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| OTHER INFORMATION |
|---|
| What are your strengths? |
| What are your areas for growth? |
| Please share any other pertinent information about yourself or your history that may help me to know and understand you, so I may effectively support your needs. |

All information is provided voluntarily and is accurate to the best of my knowledge. I understand and agree that the information will be used to develop interventions and/or courses of action.

Date: _____

Printed Name: _____

Signature: _____