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.

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 50 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 at least 24 hours prior to our session by calling the Revelations front office staff at (540) 602-2545 or by emailing me. The practice voicemail has a time and date-stamp to track the time that you call to cancel. The two exceptions to this 24-hour cancellation rule are: 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 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 fewer than 24-hours 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

Professional Service	Time	Fees
Initial Evaluation	50 minutes	$145
Individual Therapy	50 minutes	$120
No show/Late Cancel of fewer than 24 hours	N/A	$60
Letter/Report to a Third Party	N/A	$100
Attendance at a Meeting Outside of Office	N/A	$200
Subpoena to Appear in Court	N/A	$1000

Payments are to be made directly to "Revelations Counseling & Consulting, LLC"

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 10 minutes worth of 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 voicemail 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 perceive it as an emergency situation, go to your local hospital or dial 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 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, 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 messages or messages with personal or substantive content through email. Email correspondence is for scheduling purposes only.

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 choose, 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. However, 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

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 under age 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 a 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 is usually 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.

Occasionally, I may seek consultation with the Chief of Clinical Services at Revelations Counseling and Consulting, Mrs. Joanne Strawder, LCSW and other therapists who may specialize in particular topics relevant to your therapy. I will request your permission before seeking consultation from other than my co-therapists at Revelations, 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

As a general practice 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). 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 inquire about my training and experience, 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 completed my Master's Degree in Social Work from the National Catholic School of Social Service at Catholic University of America and am a Licensed Clinical Social Worker (LCSW, LICSW) through the Board of Social Work in the Commonwealth of Virginia and the District of Columbia. I am also a certified Oncology Social Worker (OSW-C). My training includes work with children, adolescents, and adults. My clinical interests include, depression, anxiety, chronic illness, cancer, end-of-life, and grief. I have a certificate in pastoral ministry and am trained to integrate religious or faith traditions in my therapeutic approach. My approach to therapy includes solution focused therapy and cognitive behavioral therapy through the lens of attachment and relationship.

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 Victoria Tripp, 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: _____
Patient/Parent or Guardian

Date: _____

Signed: _____
Patient/Parent or Guardian

Date: _____

Witness Printed Name:

_____

Signature: _____ **Date:** _____

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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:	
☐ Preferred ☐ Texts Okay ☐ Voicemail Okay	☐ I would like to receive appointment reminders.	
Home Phone	Work Phone:	
☐ Preferred ☐ Texts Okay ☐ Voicemail Ok	☐ Preferred ☐ Texts okay ☐ Voicemail Okay	
Current Marital Status:		
☐ Single ☐ Engaged ☐ Married	☐ Separated ☐ Divorced ☐ 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):	☐ Spouse	☐ Children	☐ Parents	☐ Other	☐ Alone

Who were you referred by?	May I have permission to thank that person?

Emergency Contact:	Phone Number:	Relationship to You:

CONFIDENTIAL CLIENT INFORMATION

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:				
☐ Mild	☐ Moderate	☐ Severe	☐ Totally Incapacitating	
Where are your concerns causing the most problems? (Check all that apply)				
☐ Home	☐ Work	☐ Marriage	☐ Other Relationships	☐ 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):	
□ Under too much pressure/feeling stressed.	□ Blackouts or temporary of loss of memory
□ Excessive anxiety or worry	□ Loss of appetite/increased appetite
□ Feeling lonely	□ Lacking self-confidence
□ Angry feelings	□ Issues with food and/or weight
□ Concerns about finances	□ Abuse of alcohol and/or non-prescription drugs
□ Feeling "numb" or cut off from emotions	□ Delusions
□ Angry outbursts	□ Feeling distant from God
□ Excessive fear of specific places/objects	□ Hallucinations
□ Difficulty making friends	□ Inability to concentrate while at work/school
□ Feeling as if you'd be better off dead	□ Crying spells
□ Feeling that people are "out to get you"	□ Nightmares
□ Feeling manipulated or controlled by others	□ Obsessions or compulsions with specific activities
□ Difficulty making decisions	□ Inability to control thoughts
□ Loss of interest in sexual relationships	□ Feeling trapped in rooms/buildings
□ Concerns about physical health	□ Hearing voices
□ Insomnia (no sleep) or Hypersomnia (sleep all the time)	□ Loss of interest in usual activities/lack of motivation

CONFIDENTIAL CLIENT INFORMATION

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?	□	□	
Had suicidal thoughts or threats?	□	□	
Had suicidal gestures and/or attempts?	□	□	

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?

CONFIDENTIAL CLIENT INFORMATION

PERSONAL & FAMILY HISTORY			
Have you ever experienced any traumatic events (e.g. accident, death of loved one, combat)? If yes, please describe.			□ I prefer to discuss in session.
Have you ever experienced physical, sexual, verbal, or emotional abuse, family violence, or neglect? If yes, please describe.			□ I prefer to discuss in session
Is there a family history of mental health disorders?	□ Yes	□ No	If yes, please describe
Is there a family history of substance abuse?	□ Yes	□ No	If yes, please describe.
Is there a family history of suicide?	□ Yes	□ No	If yes, please describe.
How would you describe your childhood?			
How would you describe your developmental history (learning disorders, meeting developmental markers)?			
How would you describe your social history (ability to make and keep friends, etc.)?			

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?			

CONFIDENTIAL CLIENT INFORMATION

EDUCATIO N	
Highest Level of Education Completed:	Field of Study (if applicable):
EMPLOYMENT	
Occupation:	Current Employer:
Current Work Difficulties:	

RELIGIOUS BACKGROUND (OPTIONAL)			
Do You Believe in God?	□ Yes	□ No	□ Unsure
Religious Preference:		What house of worship do you currently attend?	
How much influence does your faith have on your day-to-day activity?			
How would you describe your spiritual or faith history?			
Are clergy providing you with pastoral support?	□ Yes	□ 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.

CONFIDENTIAL CLIENT INFORMATION

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: _____