Information and Consent for Counseling

I am pleased that you have elected to participate in counseling. This document is designed to ensure that you understand our professional relationship.

I. Client Agreement/Contract: As a professionally trained counselor, I desire to work with clients who have the capacity to resolve their own challenges with my assistance. Some clients need only a few counseling sessions to achieve these goals, while others may require months or years of counseling. As a client, you have the right to end our counseling relationship at any point. If counseling is successful, you should feel that you are able to face your immediate challenges.

Although your sessions may be very intimate psychologically, it is important for you to realize that it is a professional relationship rather than a social one. Please do not invite your counselor to social gatherings, offer gifts, or ask them to relate to you in any way other than in the professional context of your counseling sessions. I will keep confidential anything that you say with the following exceptions: (1) you direct me to tell someone else, (2) I determine that you are a danger to yourself or others, or (3) I am ordered by a court to disclose information. Also, (4) *it is mandatory that I report child abuse of any kind (physical, sexual, verbal and/or emotional)*.

In addition, by signing this form, you are consenting to have your case discussed in counselor supervision time to time. While names are not routinely used, you need to be aware of the fact that the supervisor may have access to the file and may be consulted on occasion.

By signing this form you are acknowledging that you agree to this arrangement; which I believe this provides the best level of care.

Sessions are approximately 45 minutes in duration. Please note that it is impossible to guarantee any specific results regarding your counseling goals. I will help you identify your issues, but it is up to you to do the work. Together we will work to achieve the best possible results for you.

II. Legal Issues: If you are in the midst of any type of legal issue such a dispute with your employer, separation/divorce, or disability please inform your counselor immediately. Should the therapist's involvement be requested, clients will be responsible for all fees incurred. In the case of divorce, please be aware that in counseling individuals under the age of 14 whose parents are divorced, I will need either (1) signed permission from both parents or (2) a copy of the custody order indicating that the parent bringing the child has sole legal custody. In general, please be aware that in many legal situations, the courts can subpoena your medical records without your permission.

III. Payment Policy: As your counselor, I agree to provide counseling services for you in return for a fee. The fee for each session will be due at the time of service. Any professional letters, reports, telephone sessions or consultations will be billed at the agreed upon hourly rate. Cash and checks are preferred for payment; however credit cards and health saving plan cards can be used (.0349 fee). There is a $25.00 service charge for all returned checks, and cash payments may be required for subsequent visits. I do not accept insurance and have no contractual agreement with any insurance company. A receipt containing adequate information to submit for out-of-network benefits can be provided if you would like.

IV. Cancellation/Office Hours: In the event that you will not be able to keep an appointment, 48 hours advance notice must be provided, otherwise you will be responsible for paying a $65.00 cancellation fee. The office is open during regular business hours and the voice mail system for leaving a message is available 24 hours a day. Cancelling without sufficient advance notice 3 times within 2 months may be considered non-responsive and may result in the need to terminate the counseling relationship (as described in section VI).

V. Emergencies: Services are provided on an outpatient basis. Private practice clinicians cannot assume responsibility for client's day to day functioning, as some more intensive treatment programs are designed to do. It is the responsibility of the client to discuss expectations of after-hours care with the therapist upon intake so that, if necessary, an appropriate referral can be made. In the case of an emergency, when a client fears harm to him/herself or another, please call 911 or go to your local emergency room. You may also refer to the emergency information sheet you are provided with at your first visit.

VI. Termination of Therapy Services: At any time, you have the right to discontinue therapy. In addition, if at any point during the therapy, I either assess that I am ineffective in helping you reach your therapeutic goals or perceive you as non-compliant or non-responsive, I will discuss with you the cessation of treatment. I will also provide an appropriate referral that may be of help to you.

My signature below indicates that I grant consent for Pam Cooper Reimund to provide counseling services and to myself and or minor members of my family. My signature below also indicates that **I understand that I am receiving these services on a fee basis and that I am responsible for all charges.** If I am the *parent of a teenager* being provided with counseling services, my signature below indicates that **I understand the need for confidentiality between my teenager and his/her therapist and that confidentiality will be maintained unless the therapist determines that my teenager is a danger to self or others.**

Client/
Guardian
Signature______________________________ Date_____________

Client/
Guardian
Signature______________________________ Date___________

Therapist _____________________________ Date ____________

HIPAA PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Therapist commitment:

Your therapist understands that medical information about you is personal and as such is committed to protecting medical information about you. Your therapist creates a record of the care and services you receive in order to provide quality care and to comply with legal and ethical requirements. This notice applies to this record of care. The therapist is required by law to keep medical about you private; give you this notice of the legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

How Medical Information May be Used and Disclose:

Your private health information (PHI) may be shared for the purpose of conducting, planning and coordinating your treatment, obtaining payment or otherwise allowed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Your PHI may be used or disclosed for purposes permitted or required by federal, state, or local law; for example, if court ordered or if you are determined to be a danger to yourself or others. There are also mandatory reporting requirements in the case of child abuse.

Email communication is not encrypted. We also do not encrypt cell phone data. While these forms of communication are not used frequently, we may on occasion transmit and/or receive data via these means.

In no case will PHI be shared for the purposes of marketing. For this reason we are not required to obtain an “opt-in election” or an “opt-out election.”

Other Uses of Medical Information:

Furthermore, in any other situation not covered by this notice, written authorization will be requested before disclosing your PHI. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

You have the right to receive a paper copy of this HIPAA notice.

You have the right to inspect and/or receive a copy of your records. We may charge a fee for the cost of copying, mailing and other related supplies/costs.

If you have questions about HIPAA or believe your privacy rights have been violated, you may file a written request/complaint with your therapist or with the Secretary of the Department of Health and Human Services. There will be no retaliation or action taken against you for filing such complaint.

I have read the HIPAA Privacy Policy.

Name: ____ (Printed)

Signature: ____ Date: ____________________________

Client Information and History

Personal Information			
Name:	Date of Birth:	Today's Date:	
Street Address:	City:	State:	Zip
Phone Numbers – *Please check preferred contact number below.*			
Home Phone: ❑	Cell Phone: ❑	Work Phone: ❑	

Family Information		
Relationship Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Other ______________________________		
Children: ❑ Yes (If yes, indicate number, names and ages) ❑ No	Number of Children:	Number at Home:
Names and Ages:		

Employment Information
Employed: ❑ No ❑ Yes (Occupation: _______________________ ❑ Full-time ❑ Part time Employer: __________________________)
Student: ❑ N/A ❑ Yes (School: ___________________________ ❑ Full-time ❑ Part time

Medical/Health Information		
Primary Care Physician:	PCP Phone number:	
PCP Address:		
Current Non-Psychiatric Conditions and Medications:		
Condition	Medication	Start Date
Other Non-medicated, relevant medical conditions? ❑ No ❑ Yes (specify)		

Psychiatric Medications:

Current	Past		Current	Past		Current	Past	
❑	❑	Abilify (aripiprazole)	❑	❑	Focalin	❑	❑	Remeron (mirtazapine)
❑	❑	Adderall (amphetamine)	❑	❑	Geodon (ziprasidone)	❑	❑	Restoril (temazepam)
❑	❑	Ambien (zolpidem)	❑	❑	Klonopin (clonazepam)	❑	❑	Risperdal (risperidone)
❑	❑	Ativan (lorazepam)	❑	❑	Lamictal (Lamotrigine)	❑	❑	Ritalin (methylphenidate)
❑	❑	Celexa (citalopram)	❑	❑	Lexapro (escitalopram)	❑	❑	Seroquel (quetiapine)
❑	❑	Buspar (buspirone)	❑	❑	Lithium	❑	❑	Strattera (atomoxetine)
❑	❑	Concerta (methylphenidate)	❑	❑	Luvox (fluvoxamine)	❑	❑	Valium (diazepam)
❑	❑	Cymbalta (duloxetine)	❑	❑	Neurontin (gabapentin)	❑	❑	Wellbutrin (bupropion)
❑	❑	Depakote (valproate)	❑	❑	Paxil (paroxetine)	❑	❑	Xanax (alprazolam)
❑	❑	Desryl (trazedone)	❑	❑	Pristiq (desvenlafexine)	❑	❑	Zoloft (sertraline)
❑	❑	Effexor (venlafaxine)	❑	❑	Prozac (fluoxetine)	❑	❑	Other__________________

Previous Levels of Mental Health Care
Previous Outpatient Counseling? ❑ No ❑ Yes If yes, approximate dates: _______________________ Helpful? ❑ Yes ❑ No
Previous Intensive Outpatient Counseling? ❑ No ❑ Yes If yes, approximate dates: _____________________ Helpful? ❑ Yes ❑ No
Previous Psychiatric Hospitalization? ❑ No ❑ Yes If yes, approximate dates: _______________________ Helpful? ❑ Yes ❑ No

Substance Use		
Tobacco:	❑ No ❑Yes	Current: ❑ Yes ❑ No (Approximate dates from ________ to ________)
Alcohol:	❑ No ❑ Yes	Current: ❑ Yes (Approximate number of drinks per week ❑ < 3 ❑ 3 – 6 ❑ >6 ❑ No (Approximate dates from _________ to _________)
Recreational Drugs:	❑ No ❑ Yes	Current: ❑ Yes ❑ No (Approximate dates from ________ to ________)

Family History of Mental Health or Substance Abuse Issues

Mental Health: ❑ No ❑ Yes Condition? __________________________ Family Member ?___________________________________

Condition? __________________________ Family Member? ___________________________________

Condition? __________________________ Family Member? ___________________________________

Condition? __________________________ Family Member? ___________________________________

Substance Abuse: ❑ No ❑ Yes Substance? ________________________ Family Member? ___________________________________

Substance? ________________________ Family Member? ___________________________________

Substance? ________________________ Family Member? ___________________________________

Substance? ________________________ Family Member? ___________________________________

Religious Background

Religious tradition observed in childhood:

Is faith/spirituality an important part of your life? ❑ No ❑ Yes If yes, Denominational preference: ___________________________

What brings you to counseling?

How did you hear about this counseling office?

❑Brochure ❑Internet Search/Website ❑Facebook ❑Doctor's Office ❑Other ________________________________

Please rate yourself on each of the symptoms listed below:

		Never (0)	Rarely (1)	Occasionally (2)	Frequently (3)	Very Frequently (4)	N/A Or Unknown
1	Frequent feelings of nervousness or anxiety						
2	Panic Attacks						
3	Avoidance of places because of fear of having an anxiety attack						
4	Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)						
5	Periods of heart pounding, nausea or dizziness						
6	Tendency to predict the worst						
7	Multiple persistent fears or phobias (such as dying, doing something crazy)						
8	Conflict avoidance						
9	Excessive fear of being judged or scrutinized by others						
10	Quick startle or tendency to freeze in anxiety provoking or intense situations						
11	Seems shy, timid, and easily embarrassed						
12	Bites fingernails, picks skin, or pulls hair/eyelashes						
13	Persistent sad, or “empty” mood						
14	Loss of interest or pleasure in activities that are usually fun or in being around people/friends						
15	Restlessness, irritability, or excessive crying (circle all that apply)						
16	Feelings of guilt, worthlessness, helplessness, pessimism (circle all that apply)						
17	Sleeping too much or too little, early-morning awakening (circle all that apply)						
18	Decreased appetite and/or weight loss or overeating and/or weight gain (circle all that apply)						
19	Decreased energy, fatigue, feeling “slowed down”						
20	Thoughts of death or suicide, or suicide attempts						
21	Difficulty concentrating, remembering, or making decisions						
22	Persistent worry about and/or physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain (circle those that apply or ___________________)						
23	Persistent negativity or chronic low self-esteem						
24	Persistent feel of being dissatisfied or bored						
25	Excessive or senseless worrying						
26	Upset when things are out of place or things don’t go the way you planned						
27	Tendency to be oppositional or argumentative						
28	Tendency to have repetitive negative or anxious thoughts						
29	Tendency toward compulsive behaviors						
30	Intense dislike for change						
31	Tendency to hold grudges						
32	Difficulties seeing options in situations						
33	Tendency to hold on to own opinion and not listen to others						
34	Needing to have things done a certain way or you become very upset						
35	Others complain that you worry too much						

		Never (0)	Rarely (1)	Occasionally (2)	Frequently (3)	Very Frequently (4)	N/A Or Unknown
36	Tend to say no without first thinking about question						
37	Periods of abnormally elevated, depressed, or anxious mood						
38	Periods of decreased need for sleep, feel energetic on dramatically less sleep than usual						
39	Periods of grandiose notions						
40	Periods of increased talking or pressured speech						
41	Periods of too many thoughts racing through the mind						
42	Periods of markedly increased energy						
43	Periods of poor judgment that leads to risk-taking behavior (separate from usual behavior)						
44	Periods of inappropriate social behavior						
45	Periods of irritability or aggression						
46	Periods of delusional or psychotic thinking						
47	Short fuse or periods of extreme irritability						
48	Periods of rage with little provocation						
49	Often misinterprets comments as negative when they are not						
50	Periods of spaciness or confusion						
51	Periods of panic and/or fear for no specific reason						
52	Visual or auditory changes, such as seeing shadows or hearing muffled sounds						
53	Frequent periods of déjà vu (feelings of being somewhere you have never been)						
54	Sensitivity or mild paranoia						
55	Headaches or abdominal pain of uncertain origin						
56	History of a head injury or family history of violence or explosiveness						
57	Dark thoughts, may involve suicidal or homicidal thoughts						
58	Periods of forgetfulness or memory problems						
59	Trouble staying focused						
60	Spaciness or feeling in a fog						
61	Overwhelmed by tasks of daily living						
62	Feels tired, sluggish, or slow moving						
63	Procrastination, failure to finish things						
64	Chronic boredom						
65	Loses things						
66	Easily distracted						
67	Forgetful						
68	Poor planning skills						
69	Difficulty expressing feelings						
70	Difficulty expressing empathy for others						

CRISIS AND EMERGENCY PROCEDURES

Pam Cooper Reimund, MS, LPC provides counseling services in a private practice outpatient setting and therefore is limited in the ability to provide immediate responses to calls received after regular business hours. She does not provide crisis services (such as 24-hour hotline assistance) and is limited in the ability to provide emergency sessions.

Take the following steps if a crisis emerges:

1) IF IT IS A MEDICAL EMERGENCY OR IF YOU ARE PLANNING TO HURT YOURSELF OR OTHERS, PLEASE CALL 911 OR GO TO YOUR NEAREST EMERGENCY ROOM.

2) Contact a 24-hour crisis hotline in your area. You may utilize the following list:

FROM ANYWHERE IN U.S.: 1-800-SUICIDE (784-2433) Toll free call.

PENNSYLVANIA	
Chester County	(610) 918-2100
Delaware County	(610) 447-7600/ (610) 237-4210
Norristown-Montgomery County:	(800) 452-4189
Philadelphia	(215) 686-4420
Montgomery County	(610) 279-6100
Bucks County (Lower)	(215) 785-3785
Easton	(610) 252-9060
DELAWARE	
Anywhere in state	(800) 262-9800
New Castle County	(302) 761-9100
MARYLAND	
Anywhere in state	(800) 422-0009