ANNETTE KERR COUNSELING @

Mending Clinic

RESTORING HOPE

Client Information and Informed Consent for Services

Welcome and thank you for choosing Annette Kerr Counseling @ The Mending Clinic for your counseling services. Today's appointment will take approximately 60-75 minutes after you have completed the forms. We realize that beginning a process of counseling may be a major decision that you have made and may have many questions. This document is intended to inform you of our policies, state and federal laws, and your rights. If you have any questions or concerns, please ask and we will try our best to give you all the information you need. When you sign this document, it will represent an agreement between you and Mending Clinic.

Our Counseling Center

We are dedicated to providing the highest quality in our areas of respective expertise to our community. Our mission is promoting a positive emotional and psychological lifestyle for our clients through counseling and psychotherapy services.

Our Therapists

Annette Kerr is a therapist who graduated from a major accredited University, holding a Master's degree in Counseling. She is licensed through the Texas State Board of Professional Counselors.

If you have any complaints with a LPC or LPC-Intern,
you may contact:
Texas Board of Examiners of Professional Counselors
Texas Department of State Health Services
MC-1982
1100 West 49th Street
Austin, Texas 78756-3183
E-mail: lpc@dshs.state.tx.us
Website: http://www.dshs.state.tx.us/counselor
Telephone: (512) 834-6658
Fax: (512) 834-6677

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personality of the psychotherapist and the client and the particular problems you bring forward. There are many different methods your therapist may use to deal with the problems that you hope to resolve. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Moreover, psychotherapy has also shown to have great benefits for people who go through the process. Therapy often leads to an improved relationship, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

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Sessions
Your therapist and you will usually schedule one 50-60 minute session per week or make other arrangements, according to your needs. Once an appointment is scheduled, you will be expected to pay for it unless you provide a 24-hour advance notice of cancellation or re-schedule (unless we both agree that you were unable to attend due to circumstances beyond your control.)

Electronic Communication
Your therapist at Mending Clinic will make every effort to respond to your email promptly but cannot guarantee that any particular email message or text message will be read and responded to within any certain time frame. Because a response cannot be guaranteed, **please do not use email or text messaging in a medical emergency.** Should you choose to communicate by email or text messaging, please understand this is for appointment changes/clarification and sharing information. Therapy will not be conducted through email or text message. Any pertinent correspondence will be printed and made part of your medical record.

_____
Initials

HITECH and HIPAA
Please be aware that electronic devices run the possibility of a "breach of confidentiality" with protected information. A "breach" is defined in the new 2013 rules as the improper "acquisition, access, use or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security of privacy of the protected health information.

☐ By checking this box I agree to communicate via email or text and fully understand the risk of a potential breach in health information.

☐ By checking this box I do not agree to communicate via HITECH devices (i.e. emails, text)

By signing I am agreeing that I understand my choice and risk in the box I have checked.

X _____ **Date**_____
Signature of Client / Guardian

Court Fee Agreement
In the event of a court action in which a Mending Clinic contracted therapist is requested or required to participate, the client accepts full financial responsibility for the following fees:

Depositions, court testimony, record review and attorney conference calls:
$500 an hour with a four-hour minimum charge

Copying of records and associated administrative costs:
$20.00 per hour for labor and costs of supplies for chart copying
$25.00 for the first twenty pages of copying
$.50 per page thereafter

When any court action is required, a retainer in the range of $2,000-$5,000 is required to be paid in advance. All subpoenas are expected to be in the proper form and delivered by a process server to our office. Up to five business days are required for Mending Clinic to provide client records.

I agree that the party whose attorney issues any subpoena for depositions or court appearances will be the responsible party paying the retainer fee unless otherwise specified. By signing this document I understand this to be a binding contract.

X_____ **Date**_____
Signature of Client / Guardian

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Confidentiality & Limitations

All communication with your counselor, psychologist, or psychiatrist is confidential and will not, except under circumstances explained below, be disclosed to anyone outside of Mending Clinic unless you give written authorization to release information. You will need to sign a Release of Information Form if you wish to have Mending Clinic professional staff communicate information to anyone other than those specified below (see Consent for Limited Release of Information). **Under the HIPAA Omnibus Rule is, at the client's request, counselors may not disclose treatment information to the client's health insurance carrier for which the client has paid out-of-pocket, unless the disclosure is required by law.**

A record is kept of your work with us. It contains information you have provided us in writing as well as counseling notes of your sessions. The record remains in Mending Clinic for a period of seven years following your last visit; at that time, it is destroyed. **Your record never leaves Mending Clinic.**

It is important that you understand that all identifying information about your therapeutic treatment is kept confidential. Information solicited by phone, written, or in person about clients will not be provided. You will need to sign consent to release information before any information is provided to a third party outside our office. This condition applies also in cases where coordination of treatment is necessary with another health professional (physician or psychiatrist). However, there are exceptions and/or limitations to confidentiality. The following are limitations to confidentiality:

- In cases of immediate risk/threat of suicide or homicide on the part of the client.
- In cases of child or elderly sexual abuse or neglect
- In cases required by law.

_____
Initials

Emergency Situations

Usually we are available by phone or by email. If we are not able to answer the phone, you can leave a message in our voicemail with your name and phone number where we can reach you. We will make every effort to return you call on the same day you made it, with the exception of weekends and holidays. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the clinician/psychologist/psychiatrist on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

Professional Fees & Fee Agreement for Annette Kerr

Hour Fee Schedule is as follows:

Diagnostic & Evaluation Session (1st visit) – $110.00
Regular Office Visits (50-60 minutes) (Individuals, Couples & Play Therapy) - $ 80.00
Family Sessions (50-60 minutes) – $80.00

I understand that my appointment reserves this time exclusively for me and if I don't cancel or re-schedule my appointment with at least 24 hour advance notice, I will be responsible for a fee of the full amount of session.

_____
Initials

CONSENT TO TREATMENT:

By signing this Client Information and Consent Form as the client or Guardian of said client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. I also understand that any therapist that is providing counseling services is at a contract status with Mending Clinic.

_____ _____
Signature – Client / Guardian Date

_____ _____
Signature – Therapist Date

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Child Registration

Child's Name: _____ Date: _____

Child's Address: _____Apt: _____

City: _____State: _____ Zip Code: _____

Child's Race: _____Gender: M F Date of Birth: ____/____/_____ Age ____

Father's Name: _____Date of Birth: ____/____/_____ Age _____

Father's Employer: _____Occupation: _____

Mother's Name: _____Date of Birth: ____/____/_____ Age _____

Mother's Employer: _____Occupation: _____

Legal Guardian's Name (if different from mother & father): _____

Home Phone: _____Work Phone: _____Cell Phone:_____

E-Mail Address: _____

Does child live with both biological parents? ☐ Y ☐ N

If no, do you have a divorce decree for consent of psychological services? Please provide copy of divorce decree, no services will be provided until copy of divorce decree is obtained.

Child's School: _____Grade: _____

Was child referred to counseling? ☐ Y ☐ N If yes, by whom?_____

How did you hear about us?

☐ Friend/Family ☐ Annette's Website ☐ Psychology Today ☐ Mending Clinic Website

☐ Other_____

Names and ages of others living in your home:

Name: Age: Relationship:

_____

_____

_____

_____

_____

_____

Issues to be discussed / reasons for child being brought to counseling: _____

_____

_____

_____

Any family history of mental health treatment (*i.e., mother, father, uncle/aunt)*:

_____

_____

_____

_____

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Assessment and History Information

This information will help you and your therapist begin to clarify your therapy goals.

☐ YES ☐ NO Have you ever been treated by a psychiatrist?
If yes, Name _____ Date of last visit_____

☐ YES ☐ NO Have you ever been hospitalized for mental/behavioral or chemical dependency treatment?
If yes, where and when?_____

☐ YES ☐ NO Have you seen another therapist in the past 24 months?
If yes, who did you see? _____

Did you find anything affective/not affective_____

☐ YES ☐ NO Have you ever attempted suicide?
If yes, when and how? _____

Please place a number that best corresponds to the issue listed below:

NOT APPLICABLE 1 2 NOT VERY SERIOUS 3 4 SERIOUS 5 6 VERY SERIOUS 7

____Abuse – physical	____Abuse – sexual	____Emotional Abuse
____Abuse – neglect	____Aggression, violence	____Alcohol use
____Anger, hostility, irritable	____Anxiety, nervousness	____Distraction
____Career concerns, goals, choices	____Co-dependence	____Confusion
____Compulsions	____Cruelty to animals	____Crying, sadness
____Custody of children	____Decision-making,	____Delusions
____Depression	____Divorce, separation	____Gambling
____Drug Use (illegal)	____Eating problems	____Financial
____Drug Use (prescribed)	____Thought disorganization	____Goals
____Guilt	____Headaches	____Impulsiveness
____Judgment	____Loss of control	____Marital/Partner
____Memory problems	____Menstrual, PMS, menopause	____Mood swings
____Obsession/compulsion	____Panic/Anxiety attacks	____Parenting
____School difficulties	____Self-esteem	____Sexual concerns
____Sleep difficulties	____Suicidal thoughts	____Stress
____Tobacco use	____Temper/low tolerance	____Work problems
____PTSD		

Other:_____

In the past 36 months has there been a death of a family member or someone close to you?
☐ YES ☐ NO If yes, who?:_____When: _____
Prior to the 36 months, has there been a death of a family member or someone that was close to you?
☐ YES ☐ NO If yes, who?:_____When: _____

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Assessment and History Information

This information will help you and your therapist begin to clarify your therapy goals.

VERY POOR POOR BARELY ACCEPTABLE GOOD VERY GOOD

1 2 3 4 5 6 7

_____ I was very close and had a good relationship with my father.

_____ I was very close and had a good relationship with my mother.

_____ I was very close and had a good relationship with my siblings.

_____ I have a strong spiritual belief system.

NOT AT ALL NOT LIKE ME POSSIBLY LIKE ME LIKE ME TO A GREAT EXTENT

1 2 3 4 5 6 7

_____ I have several good friends.

_____ I enjoy spending time alone.

_____ I have a tendency of agreeing with other people to avoid confrontations.

_____ I don't like being around other people, I want to be alone.

_____ I like myself.

_____ I sometimes am confused with my identity.

NEVER VERY RARELY OCCASIONALLY FREQUENTLY VERY FREQUENTLY

1 2 3 4 5 6 7

_____ I put the needs and wishes of others first before myself even if I am not comfortable.

_____ I think I am responsible for the way others feel and their behaviors.

_____ I drink alcoholic beverages at least 3 times per week.

_____ I have a problem saying "no"

_____ Others can make me mad, frustrated, disappointed, or sad easily.

_____ I often have nightmares.

_____ I have sexual concerns that are now affecting my marriage.

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This information will help you and your therapist begin to clarify your therapy goals.

Briefly describe your reasons for seeking counseling services: _____

_____

_____

_____

What kind of things have you tried so far to handle this situation?:_____

_____

_____

_____

Fears or concerns of counseling:_____

_____

_____

_____

Goal or expectation of counseling:_____

_____

_____

_____

Any family history of mental health treatment (*i.e., parents, grandparents, siblings and extended family)*:

_____

_____

_____

_____