Adolescent Counseling Guidelines and Agreement Form

Personal Bio: Mrs. Hollomon received her Masters of Arts in Mental Health Counseling from Liberty University in Virginia in 2001, after undergraduate studies from University of Northern Colorado in Communication. She is a Licensed Professional Counselor and a Certified Professional Coach. Mrs. Hollomon's practice includes the treatment of couples, individuals, children, anxiety and depression. Mrs. Hollomon is licensed in the field of counseling in Washington (LH60077037) and is a member of Washington Mental Health Counselors Association.

Disclosure Statement & Informed Consent

Nature of Counseling: Counseling is a relationship between the therapist and client; whereby trust is the fundamental premise. The therapist's role is to provide understanding, compassion, and challenge for change; accepting and valuing the client. The client's role is to be a partner in the change process, to work toward his/her goal, and to be committed to his/her own growth. _____ **(Initial Here)**

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

>You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.

> You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.

>You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

>You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Child Protective Services of Washington State.

>You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

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Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Michelle Hollomon, LMHC to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. The chosen platform utilizes secure, encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to face" psychotherapy. _____ (Initial Here)

Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

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Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential.

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

You should also know that, by law in Washington, your parent/guardian does not have the right to see any written records I keep about our sessions, unless you give express permission for them to have access to your records.

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature _____ Date_____

Record Keeping: The client understands and agrees that the therapist's working notes are not considered part of the clinical record and will not be released to the client or to any other persons, agencies, or organizations under any circumstances. The client understands and agrees that any records obtained from other therapists, agencies, or institutions also will not be released by the therapist under any circumstances. The therapist will respond to any court order for records by providing only the dates of treatment or contacts with the client and a general summary of psychotherapy/counseling activity. The therapist will have broad discretion to release any information she deems relevant in situations where she believes the client or others to be at risk of physical

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harm, physical or sexual abuse, molestation, or severe neglect. The client may request a copy of the clinical record (there is a per page copying fee). The client may also ask the therapist to correct record data. If at any time the client desires record release to a third party, it is strongly advised to review the notes before release.

Part of providing quality care is respecting your privacy rights and maintaining confidentiality of all your records pertaining to therapy. Eastside Counseling and Coaching will not use or disclose your health information for any purpose not described in this notice without your written authorization.

_____ **(Initial Here)**

Professional Standards: If you have any questions or concerns about any respect of the professional relationship, Mrs. Hollomon would welcome an opportunity to discuss them with you. A review process for unresolved problems is available through: Department of Health, Counselor Programs , P.O. Box 47869 Olympia, WA 98504-7869. Phone: 360.664.9098.

Fees: Fees are discussed before or during your first session. The first and evaluation session is $155. The standard fee for all 50-minute sessions after that, is $125.00. You are asked to pay at the time service is rendered. Mrs. Hollomon does not accept insurance but will provide you with receipts for you to file with your insurance company if you chose to do so.
I agree to pay Eastside Counseling and Coaching at the rate of $120 per 50-minute session. Initials_____

Use of Credit Cards: Eastside Counseling and Coaching permits payment with credit card, cash or check. If you chose to pay with a credit card, please submit the number and expiration date below. Your credit card will be charged after your session and a receipt will be e-mailed to you. Many times, I will collect a credit card number even if you are paying with insurance so I can charge for co-pays.
Card # _____ Exp Date: _____
I agree to remit payment by credit card for counseling services.

_____ _____
Signature Date

Legal Requests: If Mrs. Hollomon is requested by her client or subpoenaed by any attorney to testify in any court-related proceeding as a result of the therapeutic relationship, she will produce the requested information because she is required to do so by law. Mrs. Hollomon may be required to show the court her records and/or testify in court. The client will be required to reimburse Eastside Counseling & Coaching in advance at the rate of $240/hr for the following applicable records: production of any form or report pertaining to records, preparation/review time concerning depositions, preparation time for court, travel time to/from depositions and court, waiting time at deposition and court, time in deposition and court. There is also a retainer fee of $2000. **I have read the previous statement and agree. Initials_____**

Cancellations: Sessions are generally scheduled for 50 minutes. The appointment is reserved for you. You will be billed the full amount for missed appointments and cancellations of less than 24 hours notice. If Mrs. Hollomon is not available to take a call, you may leave a confidential voice mail at 425-999-9470, which will be time stamped for delivery verification. Please do not e-mail notification of cancellation or rescheduling. After two consecutive absences, Mrs. Hollomon may, at her discretion, refer you to another counselor.

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I agree to pay for missed scheduled appointments if I do not give at least 24 hours notice by phone of my wish to cancel or reschedule. Initials_____

Counseling Relationship: During the time you work together with Mrs. Hollomon, you will meet regularly for approximately 50 minutes per session. This is the time you will be billed for. Mrs. Hollomon's services will be rendered in a professional manner consistent with accepted legal and ethical standards. If you have problems with your counseling relationship, it is encouraged that you speak directly with your counselor. While benefits are expected from counseling, specific results are not guaranteed. As a client, you have the power to refuse or discuss modification of any of her counseling techniques or suggestions. Both the client and Mrs. Hollomon have the right to withdraw from the therapy process. If the counseling process is withdrawn from, Mrs. Hollomon will provide appropriate referrals upon the client's request. Therapists are expected to provide services to clients only within the boundaries of their competence. They are also expected to acknowledge, be sensitive to, and respect the diversity of values, attitudes, opinions, and culture of clients and to avoid engaging in any behavior that is discriminatory, harassing, or demeaning to others. **Initials_____**

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing or discontinuing counseling. Counseling is a process of personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and /or your understanding of yourself. Some of these changes may be temporarily distressing. The exact nature of these changes cannot be predicted. Together, you can work with your therapist to achieve the best possible results for you. **Initials_____**

Emergency/Crisis Situations: Your counselor has voice mail at 425-999-9470 if you need to get in touch with her. Mrs. Hollomon does **not** provide a 24 hour crisis counseling service. If in a life threatening situation, *always* call 911 before contacting your counselor. You may also contact the Crisis Hotline # at: 800.244.5767 or 206.461.3222 . Please notify Mrs. Hollomon if an "after hours emergency" has occurred so that a follow-up session may be scheduled if as soon as possible. **Initials_____**

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Consent to Treat

I do hereby seek and consent to take part in the confidential treatment by Michelle Hollomon, MA, LMHC, CPC. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand that after the final session or in the event that I have not attended a therapy session in three months that the client/therapist relationship will be considered closed unless I initiate further contact. I understand I have the right to refuse treatment at any time.
Initials_____

*Your signature here indicates you have read, understand and accept this document (**Disclosure Statement** and **Informed Consent Policies**) and that any questions you had about this document were answered to your satisfaction, and that you were furnished a copy of this document. By your signature, you issue consent for Mrs. Hollomon to provide counseling, you understand you financial obligations and acknowledge your commitment to conform to these documents specifications.

Print Name_____Fee_____

Insurance Benefits: I authorize my insurance benefits to be paid directly to Michelle Hollomon for the services provided. I understand that I am financially responsible for my bill with Michelle Hollomon and that any balance not covered by my insurance benefits is my responsibility. I consent to the release of diagnostic information in authorizing treatment from my managed care company, and to the release of information necessary to complete the billing process with my insurance company, and with my parent's knowledge.

_____

Signature

Client Information Form

Personal Information:

Your name: _____Today's Date:_____

Date of Birth:_____ Address: _____

_____

Primary Insured's Name and DOB _____

Home Phone: _____ Mom's Cell Phone:_____ Dad's Cell hone:_____

Where would you prefer to be called?_____ E-mail:_____

Mother's Occupation and Where:_____

Father's Occupation and Where: _____

Religious Faith: _____ Church: _____

Is your religious faith something you would like to talk about? _____

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Please List the People in Your Home:

Name	Gender	Age	Comments

Please list any medications you are taking:

_____

_____

Any emergency names and numbers besides you: _____

Please circle any difficulties that have applied to you in the past or do apply currently:

❑Engaging Peers	❑Tolerating Separation	❑Playing Cooperatively
❑Hyperactive	❑Bed Wetting	❑Forgetful
❑Academic Trouble	❑Violent Temper	❑Fire Setting
❑Animal Cruelty	❑ Assault others	❑Non-Compliant
❑Immature	❑Bizarre Behavior	❑Self-injurious
❑Threats	❑Frequently Tearful	❑Frequently Daydreams
❑Lack of Attachment	❑Often Sad	❑Easily Distracted
❑Poor Concentration	❑Breaks Things	❑Isolates Self
❑Very Shy	❑Dominates Others	❑Biting Fingernails
❑Nervous Tics	❑High Intelligence	❑Learning Problems
❑Fearful or Anxious	❑Nightmares	❑Night Terrors
❑Substance Abuse	❑Phobias	❑Associates with Acting-Out Peers
❑Temper Tantrums	❑Problems with Authority	❑Sibling Rivalry

Other:_____

Please name your ethnicity: _____

Please describe any cultural issues that contribute to current problem: _____

_____

Please describe any current stressful situations that you think has caused problems for yourself.

_____

_____

Please list any additional information that you think would be helpful: _____

_____

_____

_____

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