INDIVIDUAL GUIDELINES FORM
Welcome to Eastside Counseling & Coaching!

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Personal Bio: Mrs. Hollomon received her Master of Art 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 Mrs. Hollomon's practice includes the treatment of couples conflict, depression, anxiety and issues related to spirituality. Mrs. Hollomon is licensed in the field of counseling Washington (#60077037). She is a member of American Counselors Association and American Association of Christian Counselors. Therapeutic approach is from a cognitive behavioral perspective and goal oriented.

Disclosure Statement & Informed Consent
Your Rights and Responsibilities

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)

Confidentiality: Your relationship with Michelle Hollomon is important and confidential. Information cannot be released regarding your counseling without your written consent unless disclosure is required by state law. a) In the event of a medical emergency, emergency personnel or services may be given necessary information.

b) In the event of a threat to harm oneself or someone else, if that threat is perceived to be serious, the proper individuals must be contacted. This may include the individual against whom the threat is made.

c) In the event of suspected child or elder abuse, the proper authorities must be contacted. The actions do not have to be witnessed to be reported.

d) If ordered by a judge or other judicial officers, information regarding the client's treatment must be disclosed.

e) If the client brings a complaint against me with the State of Washington, Department of Health, client information will be released.

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f) If an attorney in the State of Washington subpoenas records, they will be released unless the client files a Protection Order within 14 days of the subpoena.

g) In the event of the client's death or disability, information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.

h) In the event the client reveals the contemplation or commission of a crime or harmful act, the therapist may release that information to the appropriate authorities.

i) In the case of a client who is a minor, information indicating that the client was the victim of a crime may be released to the proper authorities. _____ (Initial Here)

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.

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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)

Record Keeping: Document and note-taking will be timely and be an accurate accounting of the client history in treatment. 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 harm, physical or sexual abuse, molestation, or severe neglect. The client may request, at any time, a copy of the clinical record, (at a per page clerical cost). 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. A fifty-three minute initial interview is $155. The standard fee for a 53-minute session after that is $125. You are asked to pay at the time service is rendered. Mrs. Hollomon accepts some insurance and will file with those insurance companies she is contracted with as a courtesy to you. However, if she is not contracted with your insurance company, you will pay her directly and she will provide you with receipts for you to file with your insurance company if you chose to do so. You will also be billed for any services your insurance company denies.

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I agree to pay Eastside Counseling and Coaching the afore mentioned fees for service. Initials_____
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.

_____
Signature

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.
Card # _____ Exp Date: _____CVV ____ 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 45-50 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_____

Client Rights:

*Right to a copy of the clinician's client records. * Right to Contact Privacy/Security Officer

*File a complaint with provider without fear of retaliation. * File a complaint with DHHS without fear of retaliation. * Right to a copy of the Provider Disclosure material (this agreement). * Right to Request Contractual Confidentiality for Minors. 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 sometimes does allow consultation by phone for short amounts of time; however, time in excess will be billed. Although our session may be very intimate psychologically, we have a professional relationship, not a social one, as a social relationship might lead to exploitation of clients and impair objectivity in the professional role. 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. If in the unfortunate and untimely event of the therapist's death, business associate and clinician Genevieve Rideout, MA, LMHC will manage client cases. 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. Treatment risks include but are not limited to changes in family and work relationships, mood

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disruptions, and/or feeling worse before feeling better. The exact nature of these changes cannot be predicted. Together, you can work with your therapist to achieve the best possible results for you. Clients have a right to decline or terminate treatment at any time. 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_____

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_____

Client Signature, _____ Date_____
Client Signature, _____ Date_____

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Client Information Form

Your name: _____ Today's Date: _____

Date of Birth:_____ Address:_____

_____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

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

If using insurance benefits, please list insured's name _____ DOB _____

Can Eastside Counseling & Coaching send you a monthly e-newsletter? _____

Occupation and Where: _____

Religious Faith _____ Church: _____

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

Relationship Status: Married, Single, Dating, Etc. How long in present status: _____

Present Partner: _____ Religious Faith: _____

Partner's Occupation: _____ Where? _____

Comments about partner: _____

_____

Children's Names	**Gender**	**Age**	**Comments**

Family History:

Comments about your parents as a child: _____

_____

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Relationship with parents now: _____

Relationship with siblings now: _____

Is there any history of abuse in your life? ❑Yes ❑No If yes, was it: ❑verbal ❑emotional ❑physical ❑sexual

Comments: _____

List any psychiatric medications you are now taking: _____

List any health problems that for which you are now receiving medical treatment now: _____

Estimated date of last exam/medical physical: _____

Check any of the following that are problematic to you at this time:

❑Anxiety	❑Depression	❑Self Esteem	❑Sexual Issues	❑Religious Doubts
❑Grief	❑Pornography	❑Fears	❑Substance Abuse	❑Loss of Meaning
❑ Medical	❑Loneliness	❑Stress	❑Anger	❑Child Raising
❑Finances	❑Addiction	❑Infertility	❑Relationships	❑Past Regrets

What do you hope to resolve and/or accomplish by coming to counseling?

_____

_____

_____

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