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COUNSELING INFORMATION DISCLOSURE STATEMENT & CONSENT

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This framework helps to create the safety to take risks and the support to become empowered to change.

CONFIDENTIALITY

With the exception of certain instances below, True Self Counseling, LLC keeps absolute confidentiality of your therapy. If the need to disclose information arises, I will make an effort to inform you prior. Exceptions to confidentiality include: (1) Danger of harming yourself, (2) Intentions to harm another person, (2) Abuse or neglect of a child or vulnerable adult, and (4) Subpoena by a court of law.

E-mail communications with True Self Counseling are not guaranteed to be completely confidential, as emails are retained in internet service provider logs. While these logs are not typically viewed, they are available to the internet service provider.

RECORD-KEEPING

Records are kept for each session, noting topics, interventions, treatment goals, and progress. These records are maintained in a secure location. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file and the right to request that any errors be corrected. A copy of your file may be made available to another health care provider through your written request.

INSURANCE

I do not bill insurance companies. I can provide you with a statement of services to submit to your insurance company, but I cannot guarantee that they will provide reimbursement for counseling. Additionally, I will be required to provide a diagnostic code indicating a mental disorder, which will go on your permanent medical record.

TERMINATION

Typically, the decision to end therapy is made between client and therapist. Termination of therapy should be discussed at a regular session, rather than by phone. If I determine that your concerns warrant more specialized care, I may refer you to another professional. If violence is threatened, I reserve the right to terminate therapy services immediately. Referrals to other sources of care can be made available upon request.

RISKS & BENEFITS

Processing feelings that you have been avoiding for a long time may initially feel uncomfortable. Making positive changes in your life can be disruptive to existing relationships. It is important for you to consider whether these risks are worth the benefits of therapy. Most people who engage in therapy find it to be worthwhile.

OUT OF OFFICE

There are times when I am away from the office for extended periods of time. I will make my best effort to inform you in advance of such absences and provide contact information for another therapist upon request. If you experience an emergency when I am unavailable, please call 911 or go to the nearest hospital for assistance.

CLIENT RESPONSIBILITIES

Therapeutic progress is greatly determined by how much you invest in the process: you get out of it what you put into it. Your responsibilities as a client include arriving on time for scheduled sessions, being an active and committed participant, collaborating to plan your goals, keeping the counselor informed of progress, and making payment at the time of service.

PAYMENT

Payment is collected at the beginning of each session. Your fee is based on a sliding scale, determined by annual household income. The scale currently ranges from $80 to $150 per 50-minute session. Relational sessions and evaluations are billed at your regular rate + $20.

Based on the sliding scale, your session rates are: $ _____ for individual and $ _____ for relational sessions.

If we decide an extended session is warranted, the additional cost will be 25% of your regular session fee per every 15-minutes (beyond the normal 50-minute session).

LATE ARRIVAL

If you arrive late (within 15 minutes of appointment time), your session will still end at the scheduled time. If you arrive more than 15 minutes late, your session may need to be rescheduled, and payment will still be due.

CANCELLATION

Requests for cancelling or rescheduling with at least 48 hours notice are acceptable. *If you fail to cancel an appointment with at least **48 hours notice**, full payment will be due.*

COMMUNICATION OUTSIDE OF SESSION

Communication exchanges of ten minutes or less are free of charge. If phone calls, voicemail messages, and/or emails consume more than 15 minutes during the course of one week, you will be billed at your regular session fee.

TRAINING & APPROACH

I have a Master of Arts degree in Clinical Mental Health Counseling from MidAmerica Nazarene University. My background includes working with children, adolescents, and adults experiencing difficulty at various life stages. My theoretical approach is person-centered which allows the needs of the client to guide the therapy process. I use a variety of techniques, including Cognitive Behavioral Therapy, tailoring techniques to what works best for each client. I am a Licensed Clinical Professional Counselor in the state of Kansas.

COMPLAINTS

If you are displeased with the course of therapy, please discuss it with me. If you believe I have behaved unethically, you may submit a complaint to the Kansas Behavioral Sciences Regulatory Board at (785) 296-3249.

CONSENT

I have read and understand the content of this statement. I am over the age of eighteen and I agree to begin therapy with Molly Pierce, MA, LCPC. I understand that I may leave therapy at any time and agree to discuss termination of therapy with my counselor. I know I have the right to refuse therapeutic suggestions.

1st Client signature: _____ Date: _____

2nd Client signature: _____ Date: _____

Therapist: _____ Date: _____

True Self Counseling - New Client Intake

This information will be by your clinician for administrative purposes and to become familiar with your presenting concerns, history, and goals to be worked on during the counseling process. Please answer as thoroughly as you can.

Today's Date: _____

Name (s): _____ Date of Birth: _____

Address: _____

Home Phone: _____ Permission to leave message? *Yes* *No*

Cell Phone: _____ Permission to leave message? *Yes* *No*

Email: _____ Permission to email? *Yes* *No*

Referred: *Doctor*_____ *Friend* *Online* *Other*_____ Permission to thank? *Yes* *No*

Employer / Occupation / School: _____

Relationship Status: *Single* *Coupled, but not married* *Engaged* *Married* *Separated* *Divorced* *Widowed*

Dates of marriage(s), divorce(s), or death of spouse: _____

_____

Members in household:

Name:	*Relationship:*	*Age / Date of Birth:*	*What's your relationship like with this person?*

Please briefly describe the concern or situation which led you to seek counseling services at this time: _____

_____

_____

How long has this been a concern? _____

Have you experienced this before? Please describe: _____

Have you received counseling before? _____ If so, when and why? _____

_____

Was it helpful? *Yes* *No* Why or why not? _____

_____

Are you currently receiving treatment from a counseling service, therapist, psychologist or psychiatrist? *Yes* *No*

Please list current and past medications and the conditions for which they were prescribed: _____

_____

Physician & Contact Information: _____

What psychiatric or emotional difficulties are you aware of among family members? _____

_____

_____

Concerns / Symptoms:

Abuse:
- Verbal
- Emotional
- Physical
- Sexual

Affair
Anger
Anxiety
Employment
Concentration
Decisions
Depressed
Destructive
Distracted
Eating
Grief
Hair pulling
Health
Hearing voices
Homicidal thoughts
Impulsive
Inattentive
Insecure
Irritable
Legal problems
Lonely
Lying
Mean
Memory
Nervous
Nightmares
Obsessions
Overactive
Panic
Paranoid
Relationship(s):
- Partner
- Ex-partner
- Children
- Parents
- Friends
- Other:

Self-control
Self-harm
Sex
Sexual identity
Shy
Sleep
Stress
Substance Use
Suicidal
Tired
Trauma
Unhappy
Violence
Worry
Other:

Additional information or explanation: _____

_____

_____

Do you consider yourself spiritual or religious? *Yes* *No* Do you currently engage in religious practice? *Yes* *No*

What part does your spirituality/faith play in counseling? _____

_____

Strengths / Values:

Adventurous	Encouraging	Hopeful	Mature	Resilient
Assertive	Enthusiastic	Humble	Modest	Respectful
Authentic	Fair	Independent	Nurturing	Responsible
Brave	Forgiving	Integrity	Open-minded	Self-aware
Compassion	Funny	Intimacy	Optimistic	Sensitive
Connection	Generous	Intelligent	Organized	Spiritual
Contribution	Grateful	Leadership	Patient	Supportive
Creative	Hard-work	Learning	Perseverance	Thoughtful
Curious	Helpful	Listener	Personal growth	Other:
Determined	Honest	Loyal	Reliable	

Alcoholic beverages per week: _____ Have you ever been arrested for driving under the influence? *Yes* *No*

Tobacco use? *Yes* *No* Amount per day? _____

Caffeine consumption? *Yes* *No* How much per day? _____

Recreational drugs? *Yes* *No* What and how often? _____

What are your counseling treatment goals? _____

_____

_____

_____

_____

_____

Is there anything else that is important for your therapist to know?

_____

_____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Phone Number(s): _____

Waiver of Medical and Psychiatric Consultation

Kansas law KSA 65-6404 (b) (3) states that my counselor is required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that s/he may have observed while working with me or my minor children (under 17 years).

By signing below, I am waiving the immediate medical consultation between the counselor and my physician. Should the need arise for a medical consultation in the future, I will be asked to sign a *Release of Information* to allow for such consultation.

In the event that my counselor addresses the need for further consultation, and I or my minor child(ren) do not currently have a primary care physician or psychiatrist, I acknowledge that my counselor may recommend that I seek medical consultation or provide me with appropriate referrals.

I understand that I have the right not to sign this waiver and that doing so provides my counselor the full requirement to make immediate consultation. I am also aware that this waiver will become part of my client record.

Please list name(s) of **adults** being treated:	Please list name(s) **children** being treated:

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____