Cooper Counseling Services, PLLC
Misty Cooper, MS, LPC-S
10310 N 138th E Ave, Suite 201
Owasso, OK 74055
(405) 254-6081

Hello,

Welcome to Cooper Counseling Services, and thank you for allowing me to work with your child.

Before your appointment, please read the following practice policies and complete the attached paperwork.

MINOR INTAKE PACKET
INFORMED CONSENT FOR MINOR
CLIENT SERVICES CONTRACT

It's important this is completed and turned in at your first appointment. I'm happy to discuss the details with you and answer any questions you may have before we begin our initial session.

My office is located in the State Farm building behind Lanes at Coffee Creek Bowling Alley. Once you enter the building the office is located at the top of the stairs in Suite 201. I own and operate my own private practice, Cooper Counseling Services, PLLC. I rent an office in a group practice of other therapists who also own their own businesses. Given this, I share a common waiting room with other independent practitioners. There may be times when you may see other clients who are waiting to be seen in this common area. If you wish for absolute privacy, please talk to me about arranging a private exit and entry strategy for your discretion.

I look forward to meeting with you,

Misty Cooper, MS, LPC-S
Registered Play Therapist
Cooper Counseling Services, PLLC
10310 N 138th E Ave, Suite 201
Owasso, OK 74055
Phone: 405-254-6081
www.coopercounselingservice.com

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CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY

Required Documents: __Insurance Card __Driver's License
__Minor's Proof of Guardianship(if applicable) __Court Order (if court ordered for services)

Date of Assessment:_____

Identifying Information :
Name: _____
Birth date: _____Age:_____
Address: _____
City/State_____Zip:_____
Home Telephone Number: _____ Cell Phone:_____
May I leave message (voice or text) at either of these numbers? ( ) Yes ( ) No
Current School/Teacher: _____

Family Information:
Mother's Name: _____
Address: _____
City/State_____Zip:_____
Home Telephone Number: _____ Cell Phone:_____
May I leave message (voice or text) at either of these numbers? ( ) Yes ( ) No
Employer: _____ Position: _____

Father's Name: _____
Address: _____
City/State_____Zip:_____
Home Telephone Number: _____ Cell Phone:_____
May I leave message (voice or text) at either of these numbers? ( ) Yes ( ) No
Employer: _____ Position: _____

Current Concerns:
Why are you seeking services for your child?

How long have these problems occurred?

Problems perceived to be (Please circle):
Very serious Serious Not serious

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Has the child ever seen a therapist/psychologist/counselor before? If yes, please explain:

What happened that makes you seek help at this time?

What changes would you like to see in your child?

Who currently resides in the home with the child?

Marital history of biological parents:
Married Separated Deceased Divorced Never Married
Does the child have step-parents? ( ) Yes ( ) No
If yes, describe the child's relationship with either/both:

If the child is adopted:
Age when child came into the home: _____ Date of legal adoption: _____
Reason and circumstances for adoption:

When was the child told?

What has the child been told?

Name of sibling	Age	Full/Half/Step/Other	Relationship? Good,Fair,Bad

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Child Health Information: (note all health problems the child has had in past or has now)

	Weight problems		Vision problems		Allergies
	Fainting		Stomach problems		Heart problems
	Hearing problems		Asthma		Hyperactivity
	Headaches		Sinus problems		High blood pressure
	Low blood pressure		Concussions		Convulsions
	Earaches		Other		

Please explain: _____

Has the child ever been admitted to a psychiatric hospital? ( ) Yes ( ) No

If yes, please explain:

Age admitted	Dates	Reason/Diagnosis	Medications

Primary Care Physician

Name: _____ Address _____

Is the child taking any medications? ( ) Yes ( ) No If yes, please explain:

Medication	Dosage	Reason for medication	How long

Developmental milestones:

Did child meet developmental milestones (crawling, walking, talking, etc.) at normal stages?

( ) Yes ( ) No If no, please explain:

Educational History:

Has the child repeated any grades? ( ) Yes ( ) No If yes, which grade? _____

Is the child enrolled in any special education or specially modified classes? ( ) Yes ( ) No

If yes, please explain: _____

Does the child attend school on a regular basis? ( ) Yes ( ) No

Does the child make satisfactory grades? ( ) Yes ( ) No If no, please explain:

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Has the child been suspended or expelled? ( ) Yes ( ) No If yes, please explain:

Does the child participate in extracurricular activities? ( ) Yes ( ) No If yes, please list:

Other Information:
What are the child's hobbies and interests?

What are the child's strengths and talents?

INFORMED CONSENT AND CONSENT TO TREATMENT FOR MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

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Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child.
If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they 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 or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm and the police.
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children

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to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

> ***Example***: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If your child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.
>
> ***Example***: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

<u>Disclosure of Minor's Treatment Records to Parents</u>

Although the laws of Oklahoma may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a

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"zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $200 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child rights and privileges

The child can expect to be: treated nicely, tell someone if not treated nicely, not be talked to or touched in a way that is hurtful, have your family be part of your sessions, talk about what you would like to happen in therapy sessions, say 'no' to your counselor at any time, not get in trouble for doing what your rights say you can do, talk with you in a language you understand.

Child/Adolescent Patient (over age 14):

By signing below, you show that you have read and understood the policies described above in the Informed Consent for Minors form. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature* _____ Date_____

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Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. _____ _____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment. _____ _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above. _____ _____

Consent to treatment of minor

By signing below I hereby give my consent for Misty Cooper of Cooper Counseling Services, PLLC to treat _____ as a client as of this date _____.

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

Therapist Signature _____ Date_____

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CLIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

THERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it 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. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to 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 about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

PROFESSIONAL FEES

My private pay hourly fee is $125 for a 55 minute session. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $200 per hour for professional services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of $25 for records requests.

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BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

CANCELLATION POLICY

Since the scheduling of an appointment involves the reservation of a time set aside especially for you, a minimum of 24-hour notice is required for the cancellation or rescheduling. Appointments are in high demand, and your advance notice will allow another client access to that appointment time. Cancellations made prior to this window are rescheduled with no penalty. Cancellations made without 24 hours' notice but prior to the start of the session incur a $50 late-cancellation fee. No-shows or cancellations made after the start of the session incur the full session fee of $150. **This charge is typically not covered by insurance.**

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.***

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Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

CONTACTING ME

I am often not immediately available by telephone. Though I am usually in my office between 9 AM and 5 PM, I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail, that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact 911 or your family physician or go to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email Communications/Text Messaging

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication. Because text messaging is a very

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unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages unless it is in regards to setting or changing an appointment.

Social Media
I do not communicate with, or contact, any of my clients through social media platforms like Twitter, Instagram, SnapChat and Facebook.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person or disabled person is being abused or has been abused, I must make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

PATIENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN: _____ DATE: _____

THERAPIST SIGNATURE_____ DATE: _____

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Notice of Privacy Practices

Client Name: _____

Date of Birth: _____

I hereby acknowledge that I have received and been given an opportunity to read a copy of Cooper Counseling Services PLLC's Notice of Privacy Practices. I understand that if I have any questions regarding the notice of my privacy rights, I can contact Cooper Counseling Services, PLLC at: (405) 254-6081 or misty@coopercounselingservice.com.

Client Signature: _____

Parent/Legal Guardian Signature:_____

Date: _____

You may refuse to sign this acknowledgment if you wish.
___Client refuses to Acknowledge receipt
Reason given_____

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CLIENT COPY

HIPAA PRIVACY PRACTICES (PRIVATE PAY AND INSURANCE)

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how Cooper Counseling Services, PLLC may use and disclose your PHI in accordance with applicable law and the ACA Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Cooper Counseling Services, PLLC is required to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. Cooper Counseling Services, PLLC is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. Cooper Counseling Services, PLLC will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

How Cooper Counseling Services, PLLC may use and disclose Health Information about you.

For treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may discuss PHI to any other consultant only with your authorization.

For payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only discuss the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing of typing services) provided we have a written contract with the business that requires it to safeguard, the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. We may use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations (such as the counseling licensing board or the health department.)
- Required by Court Order.
- Necessary to prevent a serious or imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a p
- Verbal Permission: We may use or discuss your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise these rights, please submit your request in writing to: Cooper Counseling Services, PLLC at 10310 N. 138th East Avenue Suite 201. Owasso, OK 74055.

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Licensed Behavioral Practitioners
Licensed Marital and Family Therapists
Licensed Professional Counselors

State Board of Behavioral Health Licensure
3815 N. Santa Fe, Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
Fax: (405) 522-3691
www.ok.gov/behavioralhealth

STATEMENT OF PROFESSIONAL DISCLOSURE

Please check the appropriate license: ❑ **LPC** ❑ **LBP**

I am required by law to furnish this document to you. It requires that I inform you about my professional training, orientation /techniques, experience, fees and credentials. I am licensed to practice my profession by the State Board of Behavioral Health Licensure.

My license number is **LPC** 5580 **LBP** _____

The licensing website is **www.ok.gov/behavioralhealth** where you can access the law and regulations which govern my license. I will furnish you with printed materials about the requirements of my licensure if you so desire. You may contact (without giving your name), the State Board of Behavioral Health Licensure at:

State Board of Behavioral Health Licensure
3815 N. Santa Fe, Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
www.ok.gov/behavioralhealth

Licensee's Printed Name: Misty Cooper, MS, LPC-S

Licensee's Signature: Misty Cooper, MS, LPC-S **Date:** _____

The above-designated licensee has satisfactorily supplied me with information regarding his/her practice, licensure and professional development.

Client's Signature: _____ **Date:** _____