Reese A. Lee, M.Ed. ICAADC* NBCCH* Licensed Professional Counselor

Pennsylvania License PC OO1825

Specializing in Individual, Group and Family Counseling

Clinical Hypnotherapy

General Mental Health and Addictions Counseling

*Internationally Certified Advanced Alcohol and Drug Counselor

***National Board of Certified Clinical Hypnotherapists**

Mary U. Lee, Administration/Counselor Assistant
1661 Hardscrabble Road

Munson, PA 16860-9404

Phone 814.343.6098

www.leecounseling.net

NOTE: If you are in crisis and the office cannot be reached, contact one of these facilities:

Clearfield-Jefferson Mental Health Crisis Intervention: 800-341-5040

Clearfield Hospital: 814-765-5341

Bright Horizons: 814.768.2137

Centre County Crisis/Suicide Prevention: 800-643-5432

The Meadows: 800-641-7529

Mount Nittany Medical Center: 814-234-6110

Directions (do not hesitate to call if needed)
to 1661 Hardscrabble Road, Munson, PA
(cross streets to Hardscrabble Road are Old Turnpike Road and Colorado Road):

From Interstate 80:

Kylertown Exit 133 (old Exit 21), drive on Route 53 South for three miles. Turn left at the **green MUNSON 2 MILES sign**. Take a right at the first stop sign. Drive to the next stop sign and take another right. Drive to the 6th house on the right from that stop sign. The house is a yellow, 2-story farmhouse with a dark green door and sets close to the road. Parking is available on the paved driveway.

From Philipsburg:

Take Route 53 North 5.4 miles. Turn right just after the **green MUNSON 2 MILES sign.** Take a right at the first stop sign. Drive to the next stop sign and take another right. Drive to the 6th house on the right from that stop sign. The house is a yellow, 2-story farmhouse with a dark green door and sets close to the road. Parking is available on the paved driveway.

At night we light the front arbor in front of the house with white lights and a flood light.

CLIENT INFORMATION

(Please fill out whatever applies to you. If you have been here before, only indicate information that has changed.)

Please Print Clearly

Date _____Client's Social Security #_____Case #_____

Client's First Name_____Last Name_____ MI_____

Address_____City_____ State_____Zip_____

Telephone(Home)_____(Cell)_____

(Email) _____ (Work)_____

Birthdate _____/_____/_____ Age _____Gender _____F _____M _____

Race _____

Name of Spouse/Guardian_____Phone_____

Address _____City _____ State _____ Zip _____

Person Responsible for Payment _____

Soc. Sec. # _____

Signature of Person Responsible for Payment **X**_____

(Must be signed for services to begin)

**Calls or emails will be discreet, but please indicate any restrictions:*_____

Emergency Information

In case of emergency, contact:

Name (1)_____Relationship _____

Phone_____Work _____

Address _____City _____State _____Zip _____

Name (2)_____Relationship _____

Phone_____Work _____

Address _____City _____State _____Zip _____

Physician _____ Phone _____

Address _____City _____ State _____Zip _____

Psychiatrist _____ Phone _____

Address_____City_____State_____Zip_____

Other Physicians _____Phone _____

Current Medications _____

Allergies _____

If you enter treatment with me, may I tell your medical doctor so that we can coordinate your treatment? Yes_____ No_____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____Phone _____ Hrs _____

Spouse: _____Place _____Phone _____Hrs_____

Referral Source

How did you hear of our practice (or from whom)? _____

Address_____City _____State _____ Zip _____Phone _____ Relationship to referral source _____

May I have your permission to thank this person for the referral? Yes_____ No_____

Personal History—Children and Adolescents (<18)

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____ Grade in school: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): ____ Ext: _____

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services:

__ Anger management ____ Anxiety __ Coping ____ Depression

__ Eating disorder ____ Fear/phobias __ Mental confusion ____ Sexual concerns

__ Sleeping problems ____ Addictive behaviors __ Alcohol/drugs ____ Hyperactivity

__ Other mental health concerns (specify): _____

_____

Family History

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? ___ Yes ___ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? __ _____ Yes _____ No

If Yes, describe: _____

Client's Mother

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT

Where employed: _____ Work phone: _____

Mother's education: _____

Is the child currently living with mother? ___ Yes ___ No

__ Natural parent ___ Step-parent ___Adoptive parent __Foster home ___ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

__ Yes ___ No If Yes, please explain: _____

_____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Client's Father

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? __ Yes ___ No

__ Natural parent ___ Step-parent ___Adoptive parent __Foster home ___ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

__ Yes ___ No If Yes, please explain: _____

_____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	___	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
_____	___	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
_____	___	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
_____	___	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
Others living in the household			Relationship (e.g., cousin, foster child)	
_____	___	___ F ___ M	_____	___ poor ___ average ___ good
_____	___	___ F ___ M	_____	___ poor ___ average ___ good
_____	___	___ F ___ M	_____	___ poor ___ average ___ good
_____	___	___ F ___ M	_____	___ poor ___ average ___ good

Comments: _____

_____

_____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

__ Allergies	___ Deafness	_____ Muscular Dystrophy
__ Anemia	___ Diabetes	_____ Nervousness
__ Asthma	___ Glandular problems	_____ Perceptual motor disorder
__ Bleeding tendency	___ Heart diseases	_____ Mental Retardation
__ Blindness	___ High blood pressure	_____ Seizures
__ Cancer	___ Kidney disease	_____ Spinal Bifida
__ Cerebral Palsy	___ Mental illness	_____ Suicide
__ Cleft lips	___ Migraines	_____ Other (specify): _____
__ Cleft palate	___ Multiple sclerosis	_____

Comments re: Family Health: _____

_____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurances of miscarriages or stillborns? ___ Yes ___ No

If Yes, describe: _____

Was the pregnancy with child planned? __ Yes ___ No Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number ___ of __ total children.

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? ___ Yes ___ NoIf Yes, what amount: _____

Did the mother use drugs of alcohol? ___ Yes ___ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) _____

Yes _____ No

If Yes, describe: _____

Length of labor: _____ Induced: __ Yes ___ No Caesarean? ___ Yes ___ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

__ Breast fed	____ Milk allergies	___ Vomiting	____ Diarrhea
__ Bottle fed	____ Rashes	___ Colic	____ Constipation
__ Not cuddly	____ Cried often	___ Rarely cried	____ Overactive
__ Resisted solid food	____ Trouble sleeping	___ Irritable when awakened	____ Lethargic

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

Compared with others in the family, child's development was: ___ slow __ average ___ fast

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____

_____

Education

Current school: _____ School phone number: _____

Type of school: ___ Public ___ Private ___ Home schooled ___ Other (specify): _____

Grade: _____ Teacher: _____ School Counselor: _____

In special education? ___ Yes ___ No If Yes, describe: _____

In gifted program? ___ Yes ___ No If Yes, describe: _____

Has child ever been held back in school? ___ Yes ___ No If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? _ Yes ___ No

If Yes, describe: _____

Has the child been tested psychologically? ___ Yes ___ No

If Yes, describe: _____

Check the descriptions which specifically relate to your child.

Feelings about School Work:

__ Anxious ___ Passive _ Enthusiastic ___ Fearful

__ Eager ___ No expression _ Bored ___ Rebellious

__ Other (describe): _____

Approach to School Work:

__ Organized ___ Industrious ___ Responsible ___ Interested

__ Self-directed ___ No initiative ___ Refuses _____ Does only what is expected

__ Sloppy ___ Disorganized ___ Cooperative ___ Doesn't complete assignments

__ Other (describe): _____

Performance in School (Parent's Opinion):

__ Satisfactory ___ Underachiever _____ Overachiever

__ Other (describe): _____

Child's Peer Relationships:

__ Spontaneous ___ Follower ___ Leader ___ Difficulty making friends

__ Makes friends easily ___ Long-time friends ___ Shares easily

__ Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ___ Mother ___ Father ___ Shared ___ Other (specify): _____

Health: ___ Mother ___ Father ___ Shared ___ Other (specify): _____

Problem behavior: ___ Mother ___ Father ___ Shared ___ Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ___ Poor _ Average ___ Good ___ Excellent

Current employer: _____ Position: _____ Hours per week: _____

How have the child's grades in school been affected since working? ___ Lower ___ Same ___ Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

___ Abortion	____ Hayfever	_____ Pneumonia
___ Asthma	____ Heart trouble	_____ Polio
___ Blackouts	____ Hepatitis	____ Pregnancy
___ Bronchitis	____ Hives	_____ Rheumatic Fever
___ Cerebral Palsy	____ Influenza	____ Scarlet Fever
___ Chicken Pox	____ Lead poisoning	_____ Seizures
___ Congenital problems	____ Measles	____ Severe colds
___ Croup	____ Meningitis	_____ Severe head injury
___ Diabetes	____ Miscarriage	____ Sexually transmitted disease
___ Diphtheria	____ Multiple sclerosis	____ Thyroid disorders
___ Dizziness	____ Mumps	____ Vision problems
___ Ear aches	____ Muscular Dystrophy	____ Wearing glasses
___ Ear infections	____ Nose bleeds	____ Whooping cough
___ Eczema	____ Other skin rashes	____ Other
___ Encephalitis	____ Paralysis	_____
___ Fevers	____ Pleurisy	

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	_____	___ No __ Low ___ Med ___ High
Lunch	____ / week	_____	___ No __ Low ___ Med ___ High
Dinner	____ / week	_____	___ No __ Low ___ Med ___ High
Snacks	____ / week	_____	___ No __ Low ___ Med ___ High

Comments: _____

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination		
Dental examination		
Vision examination		
Hearing examination		

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio
2 months	___	___
4 months	___	___
6 months	___	___
18 months	___	___
4–5 years	___	___

15 months ___ MMR (Measles, Mumps, Rubella)
24 months ___ HBPV (Hib)
Prior to school ___ HepB

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ___ Yes ___ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					

Behavioral/Emotional

Please check any of the following that are typical for your child:

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drugs dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Fearful
___ Frequent injuries
___ Frustrated easily
___ Gambling
___ Generous
___ Hallucinations
___ Head banging
___ Heart problems
___ Hopelessness
___ Hurts animals
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lies frequently
___ Listens to reason
___ Loner
___ Low self-esteem
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Over active
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Psychiatric problems
___ Quarrels
___ Sad
___ Selfish
___ Separation anxiety
___ Sets fires
___ Sexual addiction
___ Sexual acting out
___ Shares
___ Sick often
___ Short attention span
___ Shy, timid
___ Sleeping problems
___ Slow moving
___ Soiling
___ Speech problems
___ Steals
___ Stomach aches
___ Suicidal threats
___ Suicidal attempts
___ Talks back
___ Teeth grinding
___ Thumb sucking
___ Tics or twitching
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Worries excessively
___ Other: _____

Please describe any of the above (or other) concerns: _____

_____

How are problem behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

Has the child/adolescent experienced death? (friends, family pets, other) ___ Yes ___ No

At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

___ Yes ___ No If Yes, describe: _____

_____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

_____

Any additional information that would assist us in understanding current concerns or problems?

_____

_____

_____

What are your goals for the child's therapy? _____

_____

What family involvement would you like to see in the therapy? _____

_____

Do you believe the child is suicidal at this time? _____ Yes _____ No

If Yes, explain: _____

_____

For Staff Use

Therapist's comments: _____

_____

_____

_____

_____

Therapist's signature/credentials: _____ Date: _____/____/_____

Physical exam: _____ Required _____ Not required

(Certifies case assignment, level of care and need for exam)

Adult Checklist of Concerns

Name: _____Date:_____
Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. **(For a child, mark any of these and then complete the "Child Checklist of Characteristics.")**

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings

(cont.)

Adult Checklist of Concerns (p. 2 of 2)

- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also “Career concerns . . . ”)
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can’t keep a job, dissatisfaction, ambition

Any other concerns or issues:

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

Child Checklist of Characteristics

Name: _____Date:_____
Age: _____Person completing this form: _____
Many concerns can apply to both children and adults. If you have brought a child for evaluation or treatment, first please mark all of the items that apply to your child on the "Adult Checklist of Concerns." Then review this checklist, which contains concerns (as well as positive traits) that apply mostly to children, and mark any items that describe your child.
Feel free to add any others at the end under "Any other characteristics."

❑ Affectionate
❑ Argues, "talks back," smart-alecky, defiant
❑ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
❑ Cheats
❑ Cruel to animals
❑ Concern for others
❑ Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
❑ Complains
❑ Cries easily, feelings are easily hurt
❑ Dawdles, procrastinates, wastes time
❑ Difficulties with parent's paramour/new marriage/new family
❑ Dependent, immature
❑ Developmental delays
❑ Disrupts family activities
❑ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
❑ Distractible, inattentive, poor concentration, daydreams, slow to respond
❑ Dropping out of school
❑ Drug or alcohol use
❑ Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
❑ Exercise problems
❑ Extracurricular activities interfere with academics
❑ Failure in school
❑ Fearful
❑ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
❑ Fire setting
❑ Friendly, outgoing, social
❑ Hypochondriac, always complains of feeling sick
❑ Immature, "clowns around," has only younger playmates
❑ Imaginary playmates, fantasy
❑ Independent
❑ Interrupts, talks out, yells
❑ Lacks organization, unprepared
❑ Lacks respect for authority, insults, dares, provokes, manipulates
❑ Learning disability
❑ *Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales (cont.)*

Child Checklist of Characteristics (p. 2 of 2)

❑ Likes to be alone, withdraws, isolates
❑ Lying
❑ Low frustration tolerance, irritability
❑ Mental retardation
❑ Moody
❑ Mute, refuses to speak
❑ Nail biting
❑ Nervous
❑ Nightmares
❑ Need for high degree of supervision at home over play/chores/schedule
❑ Obedient
❑ Obesity
❑ Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
❑ Oppositional, resists, refuses, does not comply, negativism
❑ Prejudiced, bigoted, insulting, name calling, intolerant
❑ Pouts
❑ Recent move, new school, loss of friends
❑ Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults
❑ Responsible
❑ Rocking or other repetitive movements
❑ Runs away
❑ Sad, unhappy
❑ Self-harming behaviors—biting or hitting self, head banging, scratching self
❑ Speech difficulties
❑ Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
❑ Shy, timid
❑ Stubborn
❑ Suicide talk or attempt
❑ Swearing, blasphemes, bathroom language, foul language
❑ Temper tantrums, rages
❑ Thumb sucking, finger sucking, hair chewing
❑ Tics—involuntary rapid movements, noises, or word productions
❑ Teased, picked on, victimized, bullied
❑ Truant, school avoiding
❑ Underactive, slow-moving or slow-responding, lethargic
❑ Uncoordinated, accident-prone
❑ Wetting or soiling the bed or clothes
❑ Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics:

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it?

Recipient's Rights Notification

As a recipient of services at our practice, we would like to inform you of your rights as a client. The information contained in this brochure explains your rights and the process of complaining if you believe your rights have been violated.

Your rights as a client

1. Complaints. We will investigate complaints you might have.
2. Suggestions. You are invited to suggest changes in any aspect of the services we provide.
3. Civil Rights. Federal and state laws protect your civil rights.
4. Cultural/spiritual/gender Issues. You may request services from someone with more extensive training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will help you in the referral process.
5. Treatment. You have the right to take part in formulating your treatment plan, or rescind your consent for treatment.
6. Denial of services. You may refuse services offered to you and be informed of any potential consequences.
7. Record restrictions. You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
8. Availability of records. You have the right to obtain a copy and/or inspect your protected health information; however we may deny access to certain records. We will discuss this decision with you.
9. Amendment of records. You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
10. Medical/Legal Advice. You may discuss your treatment with your doctor or attorney.
11. Disclosures. You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

Your rights to receive information

1. Your doctor/pharmacist will provide you with information describing any potential risks of medications prescribed that may be needed in the course of your treatment. The practice does not prescribe medications.
2. Costs of services. We will inform you of how much you will pay for treatment.
3. Termination of services. You will be informed as to what behaviors or violations could lead to termination of services at our practice.
4. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used.
5. Policy changes.

Our ethical obligations

1. We dedicate ourselves to serving the best interest of each client.

2. We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.

3. We maintain an objective and professional relationship with each client, as will any therapist who may cover for your regular therapist.

4. We respect the rights and views of other mental health professionals.

5. We will appropriately end services or refer clients to other programs when appropriate.

6. We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.

7. We hold respect for various institutional and managerial policies, but will help improve such policies if the best interest of the client is served.

Client's responsibilities

1. You are responsible for your financial obligations to the practice.
2. You are responsible for following the policies of the practice.
3. You are responsible to treat staff and fellow clients in a respectful, cordial manner in which their rights are not violated.
4. You are responsible to provide accurate information about yourself.

What to do if you believe your rights have been violated

If you believe that your client rights have been violated please contact us.

Consent to Treatment and Recipient's Rights

Client_____ Chart #_____

I, _____, the undersigned, affirm that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at with Reese A. Lee, Licensed Professional Counselor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that either party may discontinue therapy at any time. The practice encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the psychotherapist.

Non-Voluntary Discharge from Treatment: A client may be terminated from the practice non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the office, and/or B) the client refuses to comply with the rules agreed upon for therapy, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision or request to re-apply for services at a later date.

Client Notice of Confidentiality: Federal and/or State law and regulations protect the confidentiality of patient records maintained by the practice. Generally, the practice may not say to any person outside the practice that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the practice, against any person who works for the practice, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. It is the practice's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records, except in the cases of alcoholism and other drug abuse. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for practice evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above stated policies and agreements.

_____

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____

Witness_____Date

Documents Required for the Children of Divorced or Separated Parents

1. Unless one parent has had parental rights removed, all consent documents for the child's therapy must be signed by **both** parents.
2. If there are **custody arrangements**, in the case of divorce or separation, **a copy of those arrangements would need to be on file** with the practice before therapy begins.

Children of Divorced or Separated Parents Disclaimer

If you ever become involved in a divorce or custody dispute, I want you to understand and agree that I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) I am your child's therapist only. I do not evaluate the parents or do home studies. (2) the testimony might affect the therapy relationship, and I must put this relationship first. My statements could be seen as biased, because of the therapeutic relationship that I have with your child.

_____ _____

Signature of parent Date

_____

Printed name

_____ _____

Signature of parent Date

_____

Printed name

_____ _____

Signature of therapist Date