Informed Consent

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order to enable you and Lauren to work most effectively together, please carefully read the information below. If you have any questions, Lauren will be happy to discuss them with you.

Lauren Dack is a Master's level counselor who is a Licensed Marriage and Family Therapist and a Licensed Professional Counselor approved by the Georgia Board of Professional Counselors, Social Workers and Marriage and Family Therapists. Lauren has been working with men, women, couples, and families in the State of Georgia for 8 years.

Confidentiality: The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPPA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPPAA applies to all heath care providers, including mental heath care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their heath care records. An explanation of those rights is attached to this document.

Communications between client and counselor are confidential and will not be revealed unless required by law such as in situations of:

1.) child abuse, elder abuse, or threats of physical harm to self or others,

2.) for clinical supervision purposes,

3.) if subpoenaed by a court of law,

4). If a guardian ad litem (GAL) is appointed in a custody case involving adolescent clients I have seen for counseling services and she/he is ordered by the court to have access to mental health practitioners and records therein, I am required to provide that information as it is court ordered.

5.) The Patriot Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.

6.) I am happy to provide paperwork for you to file with your insurance company; however, in doing so, there will be a diagnosis required with the paperwork and there may be a violation of your confidentiality, as insurance companies do not always observe the same strict confidentiality polices that I do as a Licensed Associate Professional Counselor. I am also willing to share information about our counseling sessions with any other professional or agency that you wish, provided you sign a Release-of-information form.

7.) In **working with adolescents,** though legally the parent(s) or legal guardian(s) of adolescent clients are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a adolescent's therapy, I honor what the adolescent does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations.

8.) In **working with couples and families,** the couple as an entity, and the family as an entity, is my client. I am not providing individual therapy for either half of the couple or for any one member of the family although sessions with individuals in the couple/family may be a part of the couples/family therapy. I ***will not be a "secret keeper" nor will I facilitate secret keeping.*** If anything significant is revealed in an individual session that I feel the other party needs to be told, I will require it be brought up in a session together so we can work through it. If I we are unable to bring the secret to light, we will have to terminate the therapeutic relationship, and I will refer you to another therapist.

Counseling Fees: The fee for a 50 minute session is $120. For couples, the initial three 1.5 hour intake sessions cost $200 due to the amount of time outside the session counselor will spend analyzing the assessments given in the 1st session. After that, 1.5 hour sessions are $180. We ask that you keep your account current and pay by ***cash, check or credit card (make checks out to Lauren Dack Counseling, LLC***) at the beginning of the session. We do not accept insurance, but are happy to provide you with a receipt at the end of the month if you wish to file your own insurance claim. If you are experiencing financial hardship, please speak to your counselor about this, so she can work with you. In the event of lack of payments received for over 2 sessions, no further sessions will be made until the balance is paid in full.

Cancellation of Appointments: If you must cancel your appointment for any reason, please call or email Lauren at 404.913.1102 or lauren.dack@gmail.com **at least 24 business hours in advance** of your scheduled appointment. If you miss your appointment, you will be billed at the full rate. Our session is very important to me, as are you. I plan my day around our scheduled appointment, so please be considerate.

Late Appointments: Each appointment begins at the scheduled time and lasts for 50 minutes. If you should arrive late for an appointment, the appointment will begin shortly after your arrival and end at the normal time.

Telephone Calls/Emails: The purpose of email, telephone, or other electronic correspondence is to assist in our communication regarding scheduling, appointment information, homework assignments, and information regarding payment status. This type of communication is not a way to communicate therapeutic information regarding your counseling care and treatment as these matters are saved for your counseling session time. While I will take reasonable, precautions to protect your confidential information, as with any electronic communication, there is no way to completely secure communication. Should you need to contact Lauren, you may leave a message at 404.913.1102 Please leave your name, telephone number, and a brief message. Your call will be returned as soon as possible, usually within 24 business hours.

Public Contact: In the event that you see me outside of the counseling office, my policy is to not acknowledge you until or unless you respond first. If you would like to acknowledge me or not, I will not be offended as it is completely dependent upon your level of comfort and desire for discretion.

Please initial that you have read the above statements and agree with them: ________

Nature of Counseling: You have the right to choose alternatives and to participate in designing your treatment plan. The therapeutic relationship, which we establish, will be characterized by respect and cooperation. Through therapeutic techniques and methods, I will offer you ways in which you can reach your counseling goals and objectives. My services will be practiced in a professional manner that is consistent with the Georgia State Board of Examiners of Marriage and Family Therapists qualifications for ethical standards. You are entitled to an explanation of your condition and the treatment that will be provided as well as the probable duration and adverse risk involved. Please know that it is impossible to guarantee any specific results regarding your counseling goals for the counseling process, however, together we can work to achieve the best possible results for you.

Emergency Procedures: This practice is not staffed with a receptionist or paging system, therefore we are not equipped to handle emergency situations. In the case of an emergency, we recommend you contact either a hospital emergency room or the police depending on the situation. You can also call the Georgia Crisis Line at: *(800) 715-4225).*

Divorce/Custody Disputes: If you become involved in a divorce or custody dispute, I am not able to provide evaluations or expert testimony in court. You should hire a different mental professional for evaluations or testimony that you may require. My position is based on two reasons: 1) my statements will be seen as biased in your favor because we have a therapeutic relationship and 2) the testimony might affect our therapeutic relationship and I must put this relationship first. By signing this informed consent document, you are acknowledging your full understanding of and agreement on my position concerning this matter.

I, _________________________, fully understand what I have just read and voluntarily request counseling services at {Simplified} Life Solutions and I agree to these terms and conditions.
_________________________________ (signature of client) __________________________ (date)

_________________________________ (signature of Parent or Guardian) _______________ (date)

Joyful Life Counseling & Coaching
Lauren M. Dack, LMFT, LPC
Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides patient protections related to the electronic transmission of data (“the transaction rules”), the keeping and use of patient records (“privacy rules”), and storage and access to health care records (“security rules”). HIPAA applies to all heath care providers, including mental health care, and providers and health care agencies thought the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, {Simplified} Life Solutions is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

Joyful Life Counseling & Coaching
HIPAA Compliance Officer

Patient Name (print) ____

I have received a copy of {Simplified} Life Solutions Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and I may at any time, not or later, as any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy of the Patient Notification of Privacy Rights document.

___________________________________ ________________________________
Patient Signature Date

___________________________________ ________________________________
Parent Signature if patient is a minor Date

___________________________________ ________________________________
Guardian Signature if patient is legal charge Date

Consent to Correspond Electronically

While Joyful Life Counseling & Coaching takes reasonable precautions to protect your confidential information, e-mail, texting & social networking via the Joyful Life Facebook page or Twitter is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with Lauren Dack regarding my therapeutic care, the Joyful Life Counseling & Coaching and/or his/her representative has my permission to correspond via that email address and other forms of electronic communications.

I give permission for Lauren Dack to email me regarding my therapeutic care at

___________________________________@_______________________________

The purpose of e-mail and other forms of electronic communication is to communicate with the client regarding scheduling appointments, reminding clients regarding their appointments, homework assignments, follow-up care according to staff or information regarding the clients' business account. Electronic communication is not a way of communicating new information regarding care or of communicating emergency treatment. You must call and talk to your individual therapist regarding any information towards your treatment at Joyful Life Counseling & Coaching.

In Case of Emergency:
If you are in an emergency situation and need to contact someone immediately to help you, you may call the following numbers:

Georgia Crisis Line: 1-800-715-4225
Crisis Text Line: Text “start” to 741-741
Atlanta Emergency Mental Health Services: 404-730-1600
Emergency Services: 911

___ I give Joyful Life Counseling & Coaching my permission to add my e-mail address for the purpose of sending me notices of future events and other pertinent information through my e-mail.

Joyful Life Counseling & Coaching

Payment Information

Payments are required at the date of services. You may pay through cash, check or credit cards. If you wish to pay by credit card, please complete the following:

Creditcard: MasterCard VISA

Number: ____

Expiration Month _________ Year _________

CVV code ______________

Address where bill is sent:

Street ____

City _______________ State _______ Zip __________________

Name as it appears on the card: ________________________________

Joyful Life does not accept insurance as payment for services, although we will make every effort to provide the information necessary for you to file for reimbursement for individual counseling. This receipt requires me to make a diagnosis, which will be in your medical health record. You are responsible for payment at the time services are rendered.

By signing below you are indicating that you have read and agree to the above contract and that you also give authorization to Lauren Dack to release any information necessary for you to secure insurance reimbursement for fees you have paid to restoration:

_______________________________________ ________________

Client's Signature Date

_______________________________________ ________________

Counselor's Signature Date

Counseling Intake Form

The following form, which will become a part of your confidential record, will enable me to gain a quicker understanding of you. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

Name:____Date of Birth_________________Age_______Sex______

Present Address____
Street

____
City County State Zip Code

Home or Cell Phone: ________________ Can we contact you at work? Work phone: ________________

Email __________________________________

Referred by: ____________________________ May I thank them?___________________

Marital Status: Single_______ Married_______(# of Years _______) Divorced________ Separated________

Presently Living With: Parents ____ Spouse ____ Roommate__________ Alone___ Other ________________

Occupation____Total Hours/Week____________________

Employed by____Phone_______________________

Religious Affiliation_______________________________________Church_________________________

Are you a member? Yes____________ No_________________________ Active______ Inactive______

Are you interested in having Christian principles incorporated into counseling? Yes No Maybe

Family member to notify in case of emergency: Name:____

Please sign here for permission to contact your family member or loved one:_____________________________

Address:____ Phone:__________________________

Education: Circle last year completed:
GradeSchool- 1 2 3 4 5 6 7 8
HighSchool - 1 2 3 4
College - 1 2 3 4 5 6 + Other Training: ______________________________________

Family Members:

Relationship	Name	Age	Grade in School Last Completed	Occupation if Out of School
Spouse	______________________	_____	________	______________
Father	______________________	_____	________	______________
Mother	______________________	_____	________	______________
Brother(s)	______________________	_____	________	______________

	___	___	___	___
Sister(s)	___	___	___	___
	___	___	___	___
Children	___	___	___	___
	___	___	___	___

Any miscarriages or abortions? ____

General Family History:

Approximately how many times did you family move when you were young? ________________________________

Parents

If separated or divorced, how old were you at the time? ____

Father deceased? ____________ How old were you at the time? ______________________________________

Step-father deceased? ___________ How old were you at the time? ____________________________________

Mother deceased? ____________ How old were you at the time? ______________________________________

Step-mother deceased? ___________ How old were you at the time? ___________________________________

Father remarried when you were age __________ You lived with whom? _________________________________

Mother remarried when you were age __________ You lived with whom? ________________________________

Until age 18 tell how long you lived with Mother _______________________ Father ______________________ Step-mother __________ Step-father ___________ Other ______________________

How did the step-parent relate to you? (kindly, poorly, affectionately, little discipline, etc.)
____
____Natural father's occupation
____

Natural mother's occupation ____

Step father's occupation ____

Step mother's occupation ____

How many times was your father married? ________________________

Your mother? __________________________

Rate your parent's marriage: Miserable _________ Unhappy _________ Average __________ Happy _________ Very Happy _________ Their marriage lasted __________ years

Describe the relationship you have with your siblings:

Past:

Present:

Does your spouse wish to come for counseling? Yes___ No___ Maybe____

Have either of you ever filed for divorce?

Date of this marriage: Age when married: You___ Spouse____

Give a brief description of any previous marriages:____

____

Describe any physical problems you have that require medication or physical care: _________________________

____

Are you currently receiving medical treatment? Yes ______ No ______

List any prescription and over the counter drugs/vitamins, herbs, taken in the last 90 days.

____________________ dosage _______ # of times per day ______ prescribed by ______________________
____________________ dosage _______ # of times per day ______ prescribed by ______________________
____________________ dosage _______ # of times per day ______ prescribed by _________________________
List medical providers you have seen in the last 90 days ____
List any allergies ____
Primary Physician Name and phone#: _____________________________ Do you have a psychiatrist? Yes No

Circle other drugs you have used in the past 90 days: Alcohol Caffeine Nicotine Marijuana
Cocaine Heroin Pain Pills Inhalants Amphetamines/Speed Ecstasy LSD Other

Previous Counseling/Therapy Yes______ No______ If yes, when?_____________________________________

With whom? Name ____Address:_________________________

____
What experiences did you like the most and least about your last counseling experience? _______________________

____

Have you ever been hospitalized for emotional of mental reasons, including substance abuse rehab? _____yes _____ no
Year _____ Reason ____
Year______Reason ____

Is there a history of alcohol or drug use in your family? ________________________

Has a friend, family member or relative discussed concerns about your use? _______________

Have you ever been concerned about your drinking or other drug use? ___________

Briefly describe the problem that prompted you to seek counseling at this time: _________________________

____

____

____

____

Have there been times when the problem got better or disappeared? Yes _____ No ______

If yes, when? ____

What do you think helped?

____

____

____

Were there times when the problems were especially bad? Yes _____ No _____

If yes, when? ____

What made it bad? ____

____

____

What have you already done about the problem? ____

What are your goals in coming to counseling? ____

Are there other people who play a major role in causing your problems or in helping you cope with your problems?

Yes ____ No _____ Explain briefly ____

____

Is there anything else that you believe might be important for your counselor to know at this time? ________________

____

____

____

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.

0	1	2	3	4	5	6	7	8	9	10
No Concern						Moderate Concern				Extreme Concern

_____ Anger/Temper

_____ Depression

_____ Education

_____ Eating difficulties

_____ Fearfulness

_____ Nervousness

_____ Financial problems

_____ Marital problems

_____ Physical problems/Headache

_____ Pornography

_____ Problems with social relationships

_____ Problems with children

_____ Religious/Spiritual Concern

_____ Sexual Concerns

_____ Thoughts of suicide

_____ Trouble making decisions

_____ Unhappy most of the time

_____ Use of alcohol

_____ Use of alcohol by family member

_____ Use of other drugs

_____ Work

_____Worry

_____ Other (specify) ___________________________

I have read the Counseling Informed Consent and voluntarily request counseling services at **Joyful Life Counseling & Coaching** in accord with terms described on the Informed Consent document.

Signature ____ Date ________________________

For clients age 17 and under, the signature of his/her guardian or custodial parent is required.

Parent/Guardian ____ Date ________________________

PLEASE SUBMIT PAYMENT WITH THIS FORM PRIOR OR AT FIRST SESSION

Please Complete the Following Sentences:

1.) The most important thing to me is

2.) I worry about

3.) What I do best is

4.)I have sometimes felt guilty about

5.) What makes me angry is

6.) My biggest mistakes were

7.) My job

8.) What makes me nervous is

9.) My personality would be better if

10.) I often felt that mother

11.) Jesus Christ is

12.) My temper

13.) My childhood

14.) Prayer is

15.) My biggest disappointment

16.) To me, sex is

17.) I would be better liked if

18.) I often felt that father

19.) God to me is

20.) My children (child) (brothers and sisters)

21.) Women are

22.) What hurts me most is

23.) My biggest problem in life is

24.) Men are