



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 9 years.

Confidentiality: 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 keeping and use of patient records, and storage and access to health care records. HIPAA applies to all health care providers, including mental health 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 health 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 policies 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 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 \$130. For couples, the initial 50 minute intake session cost \$150 due to the amount of time outside the session counselor will spend analyzing the assessments given after the 1st session. After that, 50 minute sessions are \$130. 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 joyfullifecounseling@gmail.com **at least 48 business hours in advance in order to avoid the session fee charge, however please inform me as soon as possible when you're able.** 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 or the crisis text line 741-741.

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 Joyful Life Counseling 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 health care providers, including mental health 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 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.

Lauren is unable to be available in the case of an emergency, so please note the following options:

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.



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. For couples, please each partner will fill out an intake form. 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 or 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 | | | | | _____ | Religious/Spiritual Concern | | | | |
| _____ | Depression | | | | | _____ | Sexual Concerns | | | | |
| _____ | Education | | | | | _____ | Thoughts of suicide | | | | |
| _____ | Eating difficulties | | | | | _____ | Trouble making decisions | | | | |
| _____ | Fearfulness | | | | | _____ | Unhappy most of the time | | | | |
| _____ | Nervousness | | | | | _____ | Use of alcohol | | | | |
| _____ | Financial problems | | | | | _____ | Use of alcohol by family member | | | | |
| _____ | Marital problems | | | | | _____ | Use of other drugs | | | | |
| _____ | Physical problems/Headache | | | | | _____ | Work | | | | |
| _____ | Pornography | | | | | _____ | Worry | | | | |
| _____ | Problems with social relationships | | | | | _____ | Other (specify) _____ | | | | |
| _____ | Problems with children | | | | | _____ | | | | | |

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 BRING PAYMENT AND COMPLETED FORM TO OUR 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