

**Sandra H. McKay, BSN, M.Ed., LMFT,
AAMFT Clinical Fellow and Approved Supervisor**

1810 Peachtree Industrial Blvd. Suite 120, Duluth, GA 30097 678-777-1037

CLIENT CONTRACT AND CONSENT

Client(s) Name: _____

Parent or Guardian: _____

Standard Fees and Consent to Treatment

Fee for each counseling/psychotherapy session is \$150.

If you wish to be considered for a sliding scale fee, please indicate your gross annual family income below. This will be discussed at your first session.

I (We) _____ voluntarily request counseling/psychotherapy.

Gross Annual Family Income (including child support, trusts, inheritance, disability, etc.)

\$15,000 or less	_____	\$35,000 to \$45,000	_____
\$15,000 to \$25,000	_____	\$45,000 to \$60,000	_____
\$25,000 to \$35,000	_____	\$80,000 to \$90,000	_____
		over \$90,000	_____

CONTRACT TERMS AND CONDITIONS (please initial each)

- ____ 1. I agree to pay the standard fee of \$150 per each 50 minute session. If I qualify for an adjustment, the fee will then be \$_____. I understand that in order to qualify for the adjusted fee, I will need to provide my therapist with the requested documentation which may include a copy of my latest tax return and/or pay stub. I understand that any adjusted fee will be reevaluated every 6 months or as the conditions of my income change and that this adjusted fee may also change.
- ____ 2. I understand that **payment is due at time of service**. If you are unable to keep an appointment, **kindly give 24 hours notice**, or regular charges will apply and be charged.
- ____ 3. There will be a \$30.00 returned check fee.
- ____ 4. I understand that I will receive a form that normally suffices for insurance reimbursement.
- ____ 5. I have read The Privacy Policy and Informed Consent which follows.
- ____ 6. **IN CASE OF EMERGENCY**, please go to your nearest Emergency Room or call 911.
- ____ 7. Sandra H. McKay's services do not include court case appearances. If Sandra H. McKay is subpoenaed for any reason, there will be a special rate assessed for this service. **Please be aware that court involvement can have a deleterious effect on the therapeutic relationship.**
- ____ 8. I understand that all information disclosed within session(s) is confidential and may not be revealed to anyone outside of Holy Family Counseling Center without my written permission. The only exception is in situations where disclosure is required by law:
- a) If I present an imminent threat of harm to myself or to others.
 - b) When there is an indication of abuse of a child or vulnerable adult.
 - c) If I become gravely disabled.
 - d) By court subpoena.

By signing this form you are affirming that you have read, understand, and agree to its contents.

Signature of Client(s) and parent or guardian

Date: _____

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PRIVACY OF INFORMATION POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

My Legal Duties: State and Federal law require that I keep your medical records private. Such laws require that I provide you with this notice informing you of my privacy of information policies, your rights, and my duties. I am required to abide by these policies until replaced or revised. I have the right to revise my privacy policies for all medical records, including records kept before the policy changes were made. Any changes in this notice will be made available upon request before changes take place. The contents of material disclosed to me in an evaluation, intake, or counseling session are covered by the law as private information. I respect the privacy of the information you provide me and I abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information: Information about you may be used by myself with the therapeutic team of Holy Family Counseling Center for diagnosis, treatment planning, treatment, and continuity of care. I may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, mental health interns, and mental health professionals or business associates of this agency such as billing, quality enhancement, training, audits, and accreditation providers. Both verbal information and written records about a client cannot be shared outside myself and Holy Family Counseling Center without the written consent of the client or the client's legal guardian or personal representative. There are certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements. _____ *Initial*

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim(s) and report this information to legal authorities. In cases which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety: Health records may be released for judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, military, and when complying with worker's compensation laws.

Abuse: If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or crime, and your safety appears to be at risk, I may be required to share this information with law enforcement officials to help prevent future occurrences and to help apprehend the perpetrator.

Prenatal Exposure to Controlled Substances: Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Professional Misconduct: Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings: Health care professionals are required to release records of clients when a court order has been placed. There must be consent for me to disclose information with the couple or family deemed therapeutic or necessary for treatment of the individual, couple, or family. My services do not include court case appearances. If I am subpoenaed for any reason, there will be a special rate assessed for this service. **Please be aware that court involvement can have a deleterious effect on the therapeutic relationship.**

By signing this form you are affirming that you have read, understand, and agree to its contents.

Client Signature/Date: _____

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INFORMED CONSENT FOR COUNSELING SERVICES

Name _____ Date _____

Services and Staff:

I understand that Sandra H. McKay owns and works as part of a therapeutic team at Holy Family Counseling Center offering a wide range of counseling services, and that these services are provided by licensed psychotherapists, master level therapists, certified addiction counselors, and graduate level interns. In all cases, trainees are supervised by licensed mental health professionals. Unless I have otherwise designated, all cases are discussed within a team supervision setting in order to enhance and assure quality of care. In addition to providing direct counseling services, Sandra H. McKay provides training and consultation.

Confidentiality:

I understand that all information disclosed within session(s) is confidential and may not be revealed to anyone outside this agency without my written permission. The only exception is in situations where disclosure is required by law:

1. If I present an imminent threat of harm to myself or to others.
2. When there is an indication of abuse of a child or vulnerable adult.
3. If I become gravely disabled.
4. By court subpoena.

Electronic Mail:

With respect to electronic mail (e-mail), I am cautioned that e-mail is not a confidential means of communication. Furthermore, Sandra H. McKay cannot ensure that e-mail messages will be received or responded to if she is not available. I understand that e-mail is not the appropriate way to communicate confidential, urgent, or emergency information, or to schedule/modify/cancel appointments unless I have arranged this in advance with Sandra H. McKay.

Emergency:

Go to the nearest Emergency Room or call 911.

Session Recording:

I understand that my interviews may be video or audio recorded for the purpose of continued staff training and clinical supervision. The recordings are treated confidentially and are erased after they are used. Any concerns I have about session recording will be addressed by Sandra H. McKay. I will never be video or audio recorded without my permission or knowledge.

_____ *Initial to grant permission for session recording*

Risk and Benefits:

I understand that there is a possibility of risks and benefits which may occur in counseling. Counseling may involve the risk of remembering unpleasant events and may arouse strong emotional feelings. Counseling can impact relationships with significant others. The benefits from counseling may be an improved ability to relate with others; a clearer understanding of self, values, and goals; increased academic productivity; and an improved ability to deal with everyday stress. Taking personal responsibility for working through these issues increases the likelihood of greater growth.

Eligibility, Appropriateness, Referrals:

The delivery of services from Sandra H. McKay to me shall be contingent upon whether Sandra H. McKay and I can agree that the services are appropriate given the needs and conditions I present. If it is decided that Sandra H. McKay is not the appropriate therapist to meet my needs, I understand that I will be given referrals to resources more appropriate to my needs and goals.

I HAVE HAD THE OPPORTUNITY TO DISCUSS ANY QUESTIONS I HAVE ABOUT THIS INFORMATION.

Client's Signature: _____

Date: _____

I HAVE DISCUSSED THIS INFORMATION WITH THE CLIENT.

Staff Signature: _____

Date: _____

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Initial Assessment - Page 1 of 2 (please print)

Date: _____ **Client:** _____

Each client must complete a separate assessment. For example, husband, wife, and child each fill out a separate form.

1. **Do you have any chronic medical conditions or serious illness?** Yes ___ No ___ If yes, please describe.

2. **Are you taking any medications?** Yes _____ No _____ If yes, which ones? _____

For how long and for what reason? _____

Any allergies or drug sensitivities? _____

3. **Do you have military experience?** _____ **Please describe:** _____

4. **Are you experiencing a great deal of emotional stress or problems in your life?**

_____ Yes, a lot _____ More than usual _____ Occasionally _____ Rarely

5. **Do you have relationship problems with (check all that apply):**

_____ Family members _____ Spouse/significant other _____ Remarried family members

_____ People at work _____ Specific friends

Check items that apply to your situation:

- | | | |
|--------------------------------|----------------------------------|--|
| _____ headaches | _____ sexual problems | _____ compulsive spending |
| _____ drinking problems | _____ sexual compulsions | _____ use of pornography |
| _____ dizziness | _____ financial problems | _____ drug problems |
| _____ stomach trouble | _____ feel like crying | _____ unable to have a good time |
| _____ bowel trouble | _____ panicky feelings | _____ difficulty concentrating |
| _____ appetite change | _____ tremors or tics | _____ hard time with friendships |
| _____ feel tense, uptight | _____ always worried | _____ irritable |
| _____ unable to relax | _____ feel apart from people | _____ unusual thoughts |
| _____ feel worthless | _____ eating problems | _____ can't make decisions |
| _____ frightened, scared | _____ family conflicts | _____ weight gain or loss |
| _____ feel loss/control | _____ sleep problems | _____ suicidal thoughts _____ suicidal actions |
| _____ ready to explode | _____ angry a lot | _____ put up a good front |
| _____ lonely | _____ loss of interest in things | _____ temper problems |
| _____ low self esteem | _____ misunderstood | _____ legal problems |
| _____ anxiety/worries | _____ nightmares | _____ hyper/too much energy |
| _____ always tired/fatigued | | _____ anger/temper problems |
| _____ people are out to get me | | _____ depressed, down |
| _____ feel worthless | | _____ feel I will lose self-control |

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Initial Assessment Page 2 of 2 (please print)

6. **How is your spiritual life right now?**

In good shape Developing Needs a lot of work Very poor

7. **How many changes would you like to make in your life?**

Very many Several A few None

8. **Have you ever spoken with anyone** (psychologist, counselor, psychiatrist, etc.) **about any of your personal problems?** (If yes, who and when?)

9. **Please describe any past hospitalizations in a mental health facility.**

10. **Please list the things/problems or events that are creating the most stress in your life at the present time as well as significant losses and changes in your life.**

1. _____
2. _____
3. _____
4. _____

5. _____
6. _____
7. _____
8. _____

Goals in Counseling – Please list up to three goals you hope to achieve in counseling. Please be as specific as possible.

1. _____
2. _____
3. _____

11. **How strongly would you like to talk to a counselor here about any of your concerns?**

very much much a little not really

12. **Please state any other concerns, questions, or comments:**

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REQUEST FOR RELEASE/EXCHANGE OF CLIENT INFORMATION

I (We) _____ **HEREBY AUTHORIZE** _____
(Client Name) *(Requesting Therapist Name)*

to release/exchange information contained in my client records to the following individual(s) and/or organization

(Name and phone number of person to be contacted)

The type of information to be released might include records or information concerning attendance, treatment plan, clinical assessment, psychological history, goals and progress, prognosis, or other information pertinent to the successful treatment of said client. The purpose for such disclosure/exchange might include continuity of treatment, family involvement, community support, aftercare planning, consultation with other staff therapists or referral.

I hereby release _____ from any and all liabilities, responsibilities, damages and claims
(Requesting Therapist Name)
which might arise from the release of the information authorized above. I understand that information may be transmitted by electronic means such as FAX and/or e-mail. Portions of the information provided may not pertain exclusively to my current diagnosis. I also understand that I may revoke this consent at any time or that it expires automatically as described below.

Date, Event, or Condition of expiration: _____

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

(Signature of Client)

(Signature of Witness)

(Parent, Guardian, or Authorized Representative)

(Relationship to Client)

(Date)