MICHELLE BRUMLEY COUNSELING, PLLC.

832-532-9171

105 N. Gordon Street, Suite 202
Alvin, Texas 77511

Client's Information and Informed Consent

Welcome and thank you for considering Michelle Brumley Counseling, PLLC for your mental health needs. This document contains important information about my professional services and business policies.

Therapist

I am a Licensed Professional Counselor in private practice. All mental health care services which I provide are through my professional liability company, Michelle Brumley Counseling, PLLC.

Mental Health Services

While it may not be easy to seek help from a mental health professional, I hope you will be better able to understand your situation and feelings and move toward resolving your difficulties. I, using my knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur.

Appointments

Appointments are made by calling 832-532-9171 or emailing michelle@michellebrumleycounseling.com. Please contact the office to cancel or reschedule at least 24 hours in advance, *or your will be charged for the missed appointment*. Third-party payors will not usually reimburse for missed appointments.

Number of Visits

The number of sessions needed depends on many factors and will be discussed by us. Your initial session will involve an evaluation of your needs and depending on your circumstances further evaluative sessions may be required. At the end of the evaluation process I will be able to provide you with some first impressions of what therapy may include and a treatment plan to follow if both you and I agree to work together in therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about procedures feel, free to discuss them with me at any time. If you have doubts, I can provide a referral to another mental health professional for a second opinion.

Length of Visits

Sessions will ordinarily be 45-50 minutes in duration. The time scheduled for your appointment is assigned to you and you alone. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Relationship

Your relationship with me as your therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. I care about helping you but I am not in a position to be your friend or to have a social or personal relationship with you.

If I encounter you in a public setting, in order not to reveal your identity I will not acknowledge your presence unless addressed by you first.

I shall not give or accept a gift from a client or a relative of a client valued at more than $50, borrow or lend money or items of value to clients, or accept payment in the form of goods or services rendered by a client or relative of a client.

Goals, Purposes, and Techniques of Therapy

There can be many goals of counseling. Some of these will be long term goals such as improving the quality of your life, learning to live with mindfulness, and self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behaviors, or decreasing/ending drug use. Whatever the goals for counseling, they will be set by the clients according to what they want to work on in counseling. The counselor may make suggestions on how to reach that goal but you decide where you want to go.

Payment for Services

The charge for an individual therapy session is $140 for a 60-minute session and $80 for 30-minute session. These fees are subject to change upon sixty (60) days' prior notice to you. If you are unable or unwilling to pay the higher fee after receipt of notice, services will terminate and you will be given referrals to other competent providers. A credit card will be placed on file, in a secure HIPAA compliant system at your initial session and will be charged for failure to cancel an appointment more than 24 hours prior to the session.

You are responsible for paying at the time of your session. Payment must be made by cash, check, or credit card. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to terminate services and use an attorney or collection agency to secure payment.

Although it is my goal to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or my testimony is requested by you or required by the law, regardless of who is responsible for compelling the production or testimony, you will be charged at the time of the request or service of the subpoena (current rate is $160 per hour) for the time involved in traveling to and from the testimony location, reviewing records and preparing to testify, waiting at the location, and giving testimony. Such payments are to be made at the time or prior to the time services are rendered by the therapist. The therapist may require a deposit for anticipated court appearance and preparation.

Insurance

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information which will become part of the insurance company files. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover counseling fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee or co-payment to be covered by the patient. Either amount is to be paid at the time of the visit by check, cash, or credit card.

If I am not a participating provider for your insurance plan, I can supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated or permitted by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in treatment facilities; sexual exploitation; AIDS/HIV and other communicable disease infection and possible transmission; court orders; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situation where a therapy has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, protect, notify, or disclose; sexual exploitation by a mental health professional or member of the clergy; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; the filing of a complaint with a licensing board or other state or federal authority; to regulatory authorities in connection with their compliance or investigatory responsibilities; to employees or agents of the practice for operational purposes; for treatment consultations with other mental health professionals when deemed necessary by the therapist. **FOR FURTHER INFORMATION REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR THERAPIST IN CONJUNCTION WITH THIS CLIENT INFORMATION AND INFORMED CONSENT DOCUMENT.** By signing this information and consent form below you acknowledge receipt of a copy of the Notice of Privacy Practices.

If you have any questions regarding confidentiality, you should bring them to my attention when we discuss this matter further. By signing this information and consent form below, you are giving your consent to me to share confidential information with all persons mandated or permitted by law, with the practice providing your mental health services and payment for those services, and you are releasing and holding harmless the undersigned therapist for any departure from your right of confidentiality that may result.

Duty to Warn

In the event that I reasonably believe that you are a danger, physically or emotionally, to yourself or another person, by signing this information and consent form below, you specifically consent for me to warn the person in danger and to contact any person in position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel, and the emergency contact you provided in the intake form.

This information is to be provided at your request for use by said person **only** to prevent harm to yourself or another person. This authorization shall expire upon the termination of your therapy with me.

You acknowledge that you have the right to revoke this authorization in writing at any time to the extent I have not taken action in reliance on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices that you have received and reviewed.

You acknowledge that you have been advised of the potential of the redisclosure of your protected health information by the authorized recipients and that it may not be protected from unauthorized disclosures as required by the federal Privacy Rule.

You further acknowledge that the treatment provided to you by the undersigned therapist was conditioned on you providing this authorization.

Contact Information

You consent for me to communicate with you by mail, e-mail, and by phone at the addresses and phone numbers you provided at intake, and you agree to immediately advise me in the event of any change.

Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you do not like. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

After-Hours Emergencies

Please know that I **do not** provide twenty-four (24) hour crisis or emergency therapy services. Should you experience an emergency necessitating immediate mental health attention, immediately call 911 or if you are able to safely transport yourself, go to the nearest hospital emergency room for assistance.

Contacting Your Therapist

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. I use and respond to text messages and e-mail only to arrange or modify appointments. Please do not send emails related to your treatment or therapy sessions as electronic communications are not completely secure and confidential. **Any therapy related questions or issues will not be addressed in any electronic communication but will be dealt with during your next therapy session.** Any electronic transmissions of information by you are retained in the logs of your service provider. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. You should know that any e-mails received from you and any responses sent will become part of your therapy record.

Use of Telehealth Services

I administer live, face to face, telemental health services through a HIPPAA compliant and secure service. By scheduling an appointment for this service, you agree to the use of this medium for therapy services and will submit forms through this service.

Social Media

I do not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the therapist and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a client to surreptitiously gain access to the therapist's personal site(s) will be cause for termination of the therapy.

Therapist's Incapacity or Death

You acknowledge that, in the event of your therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your file and records. By signing this Client Information and Informed Consent form below, you give consent to allowing another licensed mental health professional selected by myself to take possession of your file and records and provide you with copies upon request, or to deliver them to a therapist of your choice. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

Audio and Video Recordings

You acknowledge and, by signing this Client Information and Informed Consent form below, agree that neither you nor I will record any part of your sessions unless we mutually agree in writing that the session may be recorded. You further acknowledge that I object to you recording any portion of your session without my written consent.

Defamation
By signing this Client Information and Informed Consent form below you agree that you will not make defamatory comments about me to others or to post defamatory commentary about the therapist on any website or social media site. In the event that defamatory remarks about the therapist are made by you, or others acting in concert with you, you further consent by signing this intake and consent form below to allowing the therapist to use confidential information necessary to rebut or defend against, or prosecute claims for, the defamation.

Cooperation of Client
You shall provide any changes of address, phone numbers, or contact information during the time period which my services are required. You shall comply with all reasonable requests in connection with therapeutic treatment. I may set boundaries including forms of client interactions and communication including ceasing to provide services to you for good cause, including without limitation: your refusal to comply with treatment recommendations, the undersigned therapist is uncomfortable working with you, or your failure to timely pay fees or deposits in accordance with this Client Information and Informed Consent form, subject to the professional responsibility requirements to which I am subject. It is further understood and agreed that upon such termination of services with me, any of your deposits remaining in my account shall be applied to any balance remaining owing to the undersigned therapist for fees and/or expenses and any surplus then remaining shall be refunded to you.

Consent to Treatment
I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time.
By signing this Client Information and Informed Consent form, I, the undersigned client acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature: _____ Date_____

Printed Name: _____

As witnessed by: _____ Date _____

Michelle Brumley, Med, LPC

I acknowledge that I received a copy of this signed Client Information and Informed Consent form and the Notice of Privacy Practices from my therapist on this ____ day of _____, 20___ .

Client Signature: _____

Please keep this copy for your records

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Consent to Treatment

I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time.

By signing this Client Information and Informed Consent form, I, the undersigned client acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature: _____ Date_____

Printed Name: _____

As witnessed by: _____ Date _____

Michelle Brumley, Med, LPC

I acknowledge that I received a copy of this signed Client Information and Informed Consent form and the Notice of Privacy Practices from my therapist on this ____ day of _____, 20___ .

Client Signature: _____

Please give this copy to your therapist

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Confidential Client Information

Welcome to Michelle Brumley Counseling, PLLC. I want to make the most of each appointment you have with me. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

Your complete name: _____
Address: _____
City: _____ State: _____ Zip/Postal Code: _____

Contact Information: _____ ☐ Home ☐ Cell ☐ Work ☐ Okay to Leave Voicemail?
Contact Information: _____ ☐ Home ☐ Cell ☐ Work ☐ Okay to Leave Voicemail?
Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work
Email: _____
May I contact you for appointment reminders? ☐ Yes ☐ No Method: ☐ Home ☐ Cell ☐ Email

Age: _____ Birthdate: _____ Gender: _____ Race/Ethnicity: _____

Education (grade completed, any postsecondary): _____
Current Occupation: _____

Person to alert in the event of medical emergency: _____
Relationship to you: _____ Phone: _____

Family Doctor: _____ Phone: _____
Psychiatrist: _____ Phone: _____

Relationship status (circle one): Single Married Partnered Separated Divorced Widowed
Spouse/partner's 1st name: _____ Age: ___ Yrs in relationship: _____
Children (gender, age): _____

Insurance Co. _____ I.D. #_____ Group # _____
Primary Insurance Holder's Name: _____ Date of Birth: _____

Have you had previous psychological care or counseling? ☐ Yes ☐ No
If yes, please give the name of the clinician(s), the months you saw them (e.g., Nov 15 - Feb 15), and the nature of the difficulty at the time.

_____
_____
_____

Have you ever been hospitalized for a psychological difficulty? ☐ Yes ☐ No
If yes, please give the dates and the nature of the difficulty at the time: _____

_____

Have you ever attempted suicide or had a plan to harm yourself? ☐ Yes ☐ No ☐ Current
If yes, please give the dates and the nature of the difficulty at the time: _____

_____

Have you, in the past, or are you currently under treatment for substance abuse? ☐ Yes ☐ No
If yes, please explain: _____

_____

Have you ever received a formal diagnosis from a mental health professional? ☐ Yes ☐ No
If yes, please explain: _____

_____

Is there any history of mental disorders/illness in your family? ☐ Yes ☐ No
If yes, please explain: _____

_____

Are spiritual/religious matters important to you? ☐ Yes ☐ No
If yes, please explain: _____

_____

Are you involved in any active legal cases? ☐ Yes ☐ No
Are you currently on probation or parole? ☐ Yes ☐ No
If yes to either, please explain: _____

_____

How would you rate the quality of your nutrition/diet/eating habits?
☐ Poor ☐ Could use improvement ☐ Adequate ☐ Above Average ☐ Excellent
Please share any food/nutrition related thoughts/issues/challenges you feel your counselor should know: _____

_____

How would you rate your current overall physical health?
☐ Poor ☐ Could use improvement ☐ Adequate ☐ Above Average ☐ Excellent
Please described your current health concerns and/or recent health changes: _____

_____

_____

Please describe any significant current or past medical problems: _____

_____

_____

_____

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Please list any medications you currently take. Include prescription and over-the-counter medications and the dosage of each.

Please check if there have been any recent changes in the following?
☐ Sleep ☐ Eating/Diet ☐ Behavior ☐ Energy Level ☐ Physical Activity ☐ General Mood ☐ Weight ☐ Stress
Please describe any changes you checked above:

Do you drink alcohol? ☐ Yes ☐ No If so, how often?
Do you smoke? ☐ Yes ☐ No If so, how often?

In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish. Use additional paper if you like.

Therapy can be a powerful force for change. In order for it to be most effective it helps to have a clear and specific goal. You may find it difficult to express your hopes for therapy in the form of a goal, but please make at least an initial effort. You can discuss this further with your therapist. Feel free to list more than one goal if you wish.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

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CREDIT CARD AUTHORIZATION FORM

By completing this form, I, _____ understand that my credit card will be charged in the following circumstances:

- Co-payments/coinsurance if I am using my insurance to pay for counseling
- Full counseling fees if I am not using insurance to pay for counseling
- Return check fees ($25)
- Full session fee in the event of an appointment cancelled less than 24 hours in advance
    - If using insurance, this will be in the contracted amount with your insurance company paid to me and not just your co-payment or coinsurance amount
- Outstanding balances over 30 days delinquent

I, _____, authorize Michelle Brumley Counseling, PLLC to charge my credit card the appropriate fee for payment of counseling services, appointments that are not cancelled 24 hours in advance, a return check fee, or outstanding balances over 30 days delinquent.

Type of Card: VISA ☐ MasterCard ☐ Other ☐_____ Exp. Date: ____/____

Name on Card: _____

Card Number: _____-_____-_____-_____

Verification/Security Code (3 digit code on back of card):_____

Billing Address:_____

City: _____State: _____ Zip: _____

_____ _____

Signature Date