Miki Bryant, MS, LPC-S, NCC, ACHT

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INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES

Name of client receiving services: _____ D.O.B. _____/____/_____

What to Expect

Sessions can be conducted in an individual or group setting. Individual sessions can last one clinical hour (approximately 55 minutes), while others are more in-depth and are scheduled for 1.5 hours. These are scheduled according to the needs of the client and determined by the therapist. Hypnotherapy is the process of psychotherapy with a client that is in an induced hypnotic state (hypnosis). Hypnosis is a treatment intervention in which the therapist induces the client into a relaxed, suggestible state and then assists client with formulating suggestions for symptom relief. During hypnotherapy, the client is safely guided through a process to access both conscious and subconscious thoughts. Hypnosis is used to assist the client in accessing the inner resources within the subconscious mind to facilitate positive life changes and the healing of emotional trauma by offering suggestions to reframe negative and unwanted habitual patterns of thinking, feeling, and behaving, into positive, healthy and empowering choices. As with any form of psychotherapy, hypnotherapy and other counseling modalities are processes that are effective over time and require a commitment from the client to participate and apply what is learned in sessions.

Missed Sessions

Your appointment time is reserved especially for you. If you cannot keep an appointment, I would appreciate at least 24 hours' notice, if at all possible. ***You will be charged the full session fee for any appointments that you do not contact me to cancel.*** Missed appointments are NOT billable to insurance. If you miss two appointments without calling, future appointments will not be scheduled until a new agreement is made.

Duty to Warn

If my counselor believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact the following emergency contacts in addition to any medical or law enforcement personnel deemed appropriate.

Name	Relationship to Client	Telephone Number
_____	_____	_____
_____	_____	_____

Contacting Miki

I can be reached via phone/text, email or website contact form and will reply promptly to all messages. *Note: text, email and website contact are not considered secure forms of communication in which full privacy can be guaranteed.*

Phone: 662-799-1415 Email: soulflowerbloom@gmail.com Web: www.soulflowerhealingarts.com

Client / Therapist Relationship

You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship, which includes social media relationships. Gifts are not appropriate, nor are any sort of trade of service for therapy service.

Emergencies

You may encounter a personal emergency, which will require prompt attention. In this event, please contact my office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because of office hours, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If your emergency/serious crisis arises after hours or on a weekend, contact me, and I will call you back as soon as possible.

If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help

Fee Structure

Counseling Services

Insurance:
(billed to insurance; copay/deductible will be less)
Diagnostic & Evaluation (1st) Session: $200.00
Individual Counseling Sessions: $200.00
Family / Couples Sessions: $200.00
Group Sessions (per hour): $50.00

Private/Self Pay:
Diagnostic & Evaluation (1st) Session: $100.00
Individual Counseling Sessions: $100.00
Family/Couple Sessions: $100.00
Group Sessions (per hour): $50.00

Fee Structure - miscellaneous
Returned Check (per check): $50.00
Collection Fee: Half the amount turned over to collections
No Show fee: $100.00

Payment/ Insurance

Payment of fees, including any required co-pays, is expected at the time of each appointment. If you are using insurance benefits, our office will file insurance claims for you, and honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, full payment is expected at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months, and in some cases the self-pay rate can be negotiable. Clients who have a balance will receive a bill around the 20th of each month. After 6 statements have been sent, clients will be turned over to collections UNLESS prior arrangements have been made.

Client Acknowledgement (Initial beside each statement)

- I understand and agree to the above policies. I affirm that I am of legal age in my state of residence or that I am the parent/legal guardian of the above-named minor child, and that I have the authority to enter into this agreement. _____
- I understand that I am responsible for my fee payment at each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Soulflower Counseling, LLC and Miki Bryant, LPC-S will honor contractual agreements made with those managed healthcare companies which stipulate specific reimbursement restrictions.
- I hereby consent to treatment by Miki Bryant, LPC-S. I understand the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, and I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible for any balance due prior to a decision to stop. _____
- I authorize the payment of medical benefits to the provider of services _____

Client Printed Name: _____

Client/ Guardian signature _____ Date:____/____/_____

Guardian printed name: _____

Confidentiality / Notice of Privacy Practices

All sessions are strictly confidential, as is the fact that you are receiving therapeutic services. I am bound by professional ethics and personal convictions to maintain your confidentiality. This document is a shorter version of the full, legally required Notice of Privacy Practice (NPP) and you may have a copy of this to read and refer to it for more information. However, we cannot cover all possible situations so please talk to our Privacy Officer about any questions you may have. After you have read this NPP we will ask you to sign a form acknowledging you have read and received a copy.

If you do not consent and sign this form, we cannot treat you

In the event that any of the following circumstances should arise, the safety of all involved parties would take precedence over confidentiality:

1. If there is reason to suspect someone has abused a child or vulnerable adult (mentally handicapped or elderly), this information will be reported to the appropriate authorities (Department of Human Services).

2. If a client or other person intends to injure or kill him or herself, this information will be shared with someone who can help prevent the injury from occurring.

3. If a client intends to cause serious harm to another person, this information will be shared with someone who is in a position to prevent the harm from occurring – and with the person who is being threatened.

4. No records relating to your sessions will be released to anyone without an authorization form signed by you. The only exception to this would be a court order from a judge to release records to a court. A subpoena from an attorney is not sufficient to release any records without your approval.

5. I may discuss your case (while maintaining your anonymity as much as possible) with a colleague for purposes of supervision. My colleagues are bound by the same ethical and legal considerations to protect your confidentiality.

6. Other than discussion of your case for supervision purposes, if any of the above circumstances arises, I will discuss the issue with you prior to breaching our confidential relationship. It is very important that you understand that I cannot discuss your case with anyone- not even family members or your attorney – without your permission. Please do not ask someone to contact me to discuss your case unless you have signed a release form authorizing the release/exchange of confidential information pertinent to your treatment between that person and me.

We will use the information about your health that we get from you or from others to mainly provide you with treatment and to arrange payment for our services. If we or you want to use or disclose (send, share, release) your information we will ask you to sign a Release of Information form.

You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example:

1. You can ask us to call you at home, instead of work, to schedule or cancel an appointment. We will try our best to do as you ask.

2.You have the right to look at the health information we have about you such as your medical and billing records. If it becomes necessary, you may ask for a copy of these records. Contact our Privacy Officer to arrange.

3. If you believe the information in your records is missing important information, you may ask us to amend your health information. This request must be made in writing and sent to our Privacy Officer.

4. You have the right to a copy of this notice.

5.You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact the offices of Miki Bryant by phone at **662-268-8129** or by e-mail at **soulflowerstudio@gmail.com** Also, you may have other rights which are granted to you by the laws of our state and these may be the same or different from the rights described above. I will be happy to discuss these situations with you now or as they arise.

Acknowledgement of Receipt of Notice of Privacy Practice:

Client/ Guardian signature:_____ Date: _____/_____/_____

Authorization for Release of Information

To be completed only after consultation with a Soulflower Guide

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Client Name _____ Client DOB _____ Client SS# _____

I authorize Miki Bryant, LPC-S

(please choose) _____ release information to, _____ communicate with, and/or _____receive information from:

Person / Organization:_____

Address _____Phone Number_____

Specific description of information:

_____

authorization will expire on _____/_____/_____ INITIALS _____

I understand that I may revoke the authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions they took before they received the revocation. INITIALS _____

Section B: Must be completed only if a health plan or health care provider has requested the authorization

What is the purpose of the disclosure? _____

The health plan or health care provider requesting the authorization will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

The patient or patient's representative must read and initial the following statements:

I understand that my health care and payment for my health care will not be affected if I do not sign this form.

INITIALS _____

I understand that I may see & copy information described on this form, & I get a copy of this form after I sign it.

INITIALS _____

authorization will expire on _____/_____/_____ INITIALS _____

I understand that I may revoke the authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions they took before they received the revocation. INITIALS _____

Client Name :_____

Client/Guardian Signature:_____ Date:_____/____/_____

Printed Name of Client /Guardian: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

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Client: _____ Date of Birth: _____ Age: _____

SSN: _____ Gender: _____ Race: _____

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

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

Home Phone: _____ Cell Phone: _____

Email Address: _____

Place of Employment: _____ Work Phone: _____

Responsible Party: _____ Relationship: _____

DOB: _____ Age: _____ SSN: _____ Gender: _____

Address (if different from client): _____City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Place of Employment: _____ Work Phone: _____

Other Parent / Spouse: _____ Relationship: _____

DOB: _____ Age: _____ SSN: _____ Gender: _____

Address (Only if different from client and/or responsible party):

_____ City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Place of Employment: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder Name: _____

Relationship to Client: _____ DOB: _____SSN: _____

Address: _____Phone:_____

ID#: _____ Group#: _____ Plan Name: _____

Secondary Insurance: _____ Policy Holder Name: _____

Relationship to Client: _____ DOB: _____SSN: _____

ID#: _____ Group#: _____ Plan Name: _____

Emergency Contact:

Name: _____ relationship:_____ phone #:_____

Name:_____ relationship:_____ phone #:_____

INTAKE FORM

Please complete the following as thoroughly as possible. Information you provide here is protected as confidential information.

Name: _____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Name of parent/guardian (if under 18 years of age)

_____

(Last) (First) (Middle Initial)

Marital/Relationship Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age(s)_____

_____

Address: _____/_____/_____/_____

(Street and Number) (City) (State) (Zip)

Home Phone: _____ Ok to leave a message? □ Yes □ No

Cell/Other: _____ Ok to leave voice message? □ Yes □ No; Text? □ Yes □ No

E-mail: _____ OK to email you? □ Yes □ No

*Please note: Email and text correspondence are not considered to be confidential mediums of communication.

Communication method you prefer I use to contact you: _____

Referred by (if any): _____

Have you previously received any type of mental health services/are you currently receiving alternative therapeutic interventions (psychotherapy, psychiatric services, acupuncture, etc.)?

□ No □ Yes, Type and Therapist/Practitioner Name(s):_____

Current Natural/ Nutritional Supplements	**Reason Taking**	**Current Prescriptions medications**	**Reason Taking**	**Previous Psychiatric medications**	**Reason Prescribed & dates**

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any **current** specific health problems:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any **current** sleep problems:

_____

3. How many times per week do you generally exercise? _____

In what types of physical exercise do you engage? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you **currently** experiencing overwhelming sadness, grief, or depression? □ No □ Yes

If yes, approximately how long has this persisted? _____

6. Are you **currently** experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you **currently** experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you **currently** in a romantic relationship? □ No □ Yes

If yes, for how long? _____ On a scale of 1-10, rate the relationship: _____

11. Have you recently experienced any life changes or stressful events? □ No □ Yes

If yes, list/describe:

_____

_____

ACE (Adverse Childhood Experiences)

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

No___ If Yes, enter 1 ___

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

No___ If Yes, enter 1 ___

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

No___ If Yes, enter 1 ___

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

No___ If Yes, enter 1 ___

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

No___ If Yes, enter 1 ___

6. Were your parents ever separated or divorced?

No___ If Yes, enter 1 ___

7. Was your mother or stepmother:

Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

No___ If Yes, enter 1 ___

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

No___ If Yes, enter 1 ___

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

No___ If Yes, enter 1 ___

10. Did a household member go to prison?

No___ If Yes, enter 1 ___

ACE Score_____

FAMILY MENTAL HEALTH HISTORY

In the following section, indicate if there is a ***family member*** with a history of any of the following. If yes, please provide the family member's relationship to you (father, grandmother, uncle, etc.)

Mental Health Issues	**Please Circle**	**List Family Member(s)**
Alcohol/ Substance Abuse	Yes/no	
Anxiety	Yes/no	
Bipolar	Yes/no	
Depression	Yes/no	
Domestic Violence	Yes/no	
Eating Disorders	Yes/no	
Obesity	Yes/no	
Obsessive Compulsive Behavior	Yes/no	
Schizophrenia	Yes/no	
Suicide Attempts	Yes/no	

ADDITIONAL INFORMATION

1. What is your current employment status/situation?

_____

2. If employed, do you enjoy your work? Is there anything stressful about your current work?

_____

_____

3. What do you consider to be your personal strengths?

_____

_____

4. What do you consider to be your personal challenges?

_____

_____

5. In one sentence, tell me what you would like to accomplish throughout the course of your sessions (consider why you are seeking counseling/therapy).

_____

_____

6. Additional information that might be beneficial in planning your therapeutic experience:

_____

_____