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Informed Consent
Child/ Adolescent Form

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order to enable you and your counselor to work most effectively together, we ask that you carefully read the information below and initial besides each, signifying that you are in agreement with the process and procedures of therapy. If you have any questions, your counselor will be happy to discuss them with you.

** Both client and parent/guardian should review these listed guidelines. For clients under the age of 18, a parent or guardian should initial beside the listed guidelines.*

_____ (initial) **THERAPIST BACKGROUND & PRACTICE:**
Lydia Minear practices psychotherapy in the state of Georgia as a Licensed Professional Counselor. She completed her graduate work at Liberty University and graduated in 2012 with a MA in Professional Counseling. Lydia practices from person-centered and psychodynamic perspectives, with an interest in the client's emotional wellbeing and personal empowerment. It is her belief that each individual has within him or herself resources for self-understanding and self-direction. Bringing these strengths to the forefront of your awareness as well as giving sensitive, thoughtful attention to emotions as they arise is a major part of the counseling process. Together she partners with you, the client, to explore the sources of pain, confusion, and frustration in your life currently - as well as your unique history, experiences, feelings, and values – in an effort to clarify your needs and move in the right direction.

_____ (initial) **RISKS AND BENEFITS OF COUNSELING:**
Counseling is an intensely personal process, which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Counseling requires a very active effort on your part. In order to be most successful, you will need to work on things we discuss outside of sessions. Please know that you have the right as the client to terminate counseling at any time. However, it is in the best interest of the therapy process that this is discussed in-session with your counselor.

There are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

_____ (initial) **CONFIDENTIALITY:**
Confidentiality is of utmost importance in protecting you, the client, and providing a safe environment for sensitive information to be discussed. Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. While keeping your identity private, I may also consult with other licensed professionals to give you the best service possible.

_____ (initial) **COMMUNICATING WITH YOUR PARENT(S)/GUARDIAN(S):**
Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of -- or would be upset by -- but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent

or guardian. Even if I have agreed to keep information confidential - to not tell your parent or guardian - I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when speaking with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you. You should also know that, by law in Georgia, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records, and doing so is strongly discouraged.

_____ (initial) **COMMUNICATION:**
Secure and private communication cannot be fully assured utilizing cell/smart phone or email technologies. By initialing, you are acknowledging that the use of any of these technologies to contact your counselor are considered non-secure. Any contact to your counselor by these means will be considered implied consent for your counselor to return messages via the same non- secure technology unless you present a written statement of further clarification.

_____ (initial) **COUNSELING FEES:**
The normal fee for a 45-min counseling session is $120.00. We ask that your account be kept current and that payment be made at each individual session. Should the fee not be paid for two sessions, no further sessions will be scheduled until the balance is paid. ***A charge of $25.00 will be made for returned checks plus the amount of the unpaid session.***

_____ (initial) **CANCELLATION OF APPOINTMENTS:**
Your appointment time is important to you, to your therapist, and to others who are in need of therapy. If you must cancel your appointment, please phone your counselor and leave a message on their voicemail at least 24 hours in advance of your scheduled appointment. ***A charge of the session fee will be made for the time reserved when cancellations are received less than 24 hours in advance, except in case of serious illness or emergency. You are personally responsible for this charge and all future appointments may be cancelled until this fee is paid.***

_____ (initial) **RECORD KEEPING:**
Your counselor may keep records of your counseling sessions and a treatment plan, which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either electronically on a USB flash drive or in a paper file and stored in a locked cabinet in the counselor's office.

_____ (initial) **TELEPHONE CALLS:**
Should you need to contact your counselor, you may leave a message on their provided phone number. For all calls that are over 5 minutes in length, your counselor may ask if you would like to schedule a session or continue the telephone call for the normal session fee of $100.00 per 45-minute session.

_____ (initial) **TEXTING:**
You may text your counselor to make or cancel an appointment. Text messaging should be used for no other reason. If texting lasts over 5 minutes in length, your counselor may ask if you would like to schedule a session or continue the conversation for the normal session fee of $100.00 per 45-minute session.

_____ (initial) **EMERGENCY PROCEDURES:**
If you have an emergency, you will need to contact either a hospital emergency room or the police depending on the situation. ***If you feel your life or someone else's is in danger call 911 immediately.***

I have read the Information Sheet and voluntarily request counseling services for my minor child in accord with terms described on the information sheet.

Custodial Parent/Guardian: _____ Date: _____

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," 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 HIPPA 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 HIPPA affords all of us. In mental health care, confidentiality and privacy are central to the success of the 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, your signature is required indicating you have received a copy of the Patient Notification of Privacy Rights document. If you have not received a copy, notify Lydia. A copy can be found on her website at www.lydiaminear.com/fees-faq/ in addition to her office.

Lydia Minear Counseling
HIPAA Compliance Officer

Patient Name (print) _____

I have received a copy of the Lydia Minear Counseling 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 that I may at any time now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy.

_____ _____
Patient Signature Date

_____ _____
Patient Signature if patient is a Minor Date

_____ _____
Guardian Signature if patient is Legal Charge Date

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

CONFIDENTIAL CHILD/ ADOLESCENT INTAKE

PERSONAL INFORMATION:

Child's Name: _____ Date of Birth: _____ Age: _____ Sex: ____

Present Address:

_____

Street / City/ State/ Zip

Child Lives with:

_____ (Relationship to Child: _____)

If parents are divorced, briefly describe custody arrangements:

_____

_____

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

Address: _____ Phone: _____

INFORMATION ABOUT CHILD'S MOTHER:

Mother's Name: _____ Age: _____ Race:

_____

Home Phone: _____ May we call? Yes/ No Leave Message? Yes / No

Cell Phone: _____ May we call? Yes / No Leave Message? Yes / No

Work Phone: _____ May we call? Yes/ No Leave Message? Yes / No

Employer: _____ Occupation: _____ Hrs/wk: _____

INFORMATION ABOUT CHILD'S FATHER:

Father's Name: _____ Age: _____

Home Phone: _____ May we call? Yes/ No Leave Message? Yes/ No

Cell Phone: _____ May we call? Yes / No Leave Message? Yes / No

Work Phone: _____ May we call? Yes/ No Leave Message? Yes / No

Employer: _____ Occupation: _____ Hrs/wk: _____

PHYSICAL/ MENTAL HEALTH CONCERNS:

Describe any physical problems that your child's had, which have required medication or physical care:

_____

_____

Is he/she currently receiving medical treatment? Yes / No

Is he/she currently taking any prescription medications? Yes/ No

If yes, please list by name and dosage:

_____

_____

_____

Child's previous counseling/therapy? Yes/ No If yes, when? _____

With whom? Therapist/ Psychiatrist Name & Agency:

_____

_____

Please list any previous Mental Health Diagnosis your child received:

_____

_____

ACADEMIC/SCHOOL INFORMATION:

Name of school: _____ Grade: _____

List previous schools attended with dates:

_____

_____

Has child ever repeated a grade? _____ If so, which one(s)? _____

How does your child get along at school?

_____

Describe difficulties in learning at school:

_____

Have other family members have learning difficulties?

_____

ADDITIONAL INFORMATION:

Primary Reason for contact (main presenting concern for child/adolescent):

_____

_____

_____

Describe what your child likes to do for fun, special interests, hobbies, etc.

_____

_____

Describe your child's religious/spiritual/and or cultural background, which is of importance to him/her:

_____

_____

Anything else you think would be important for the counselor to know:

_____

_____

FAMILY MEMBERS:
List all people now living in the household, then draw a line and list others who have lived there during the child's lifetime:

Name	**Relationship to Child**	**Age**	**Occupation**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

_____ Adjustment to Parent's Remarriage

_____ Assertiveness

_____ Body Image

_____ Depression

_____Divorce/Parents' Separation

_____ Education

_____ Eating Difficulties

_____ Family Problems

_____ Fearfulness

_____ Nervousness

_____ Personality

_____ Physical Problems

_____ Problems with social relationships

_____ Problems with children

_____ Problems with parents

_____ Problems Sleeping

_____ Religious/Spiritual Concerns

_____ Self-Esteem

_____ Self-harm

_____ Sexual Concerns

_____ Talks 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) _____

PLEASE COMPLETE THE FOLLOWING: (To be completed by child/ adolescent client.)

1. I would like

2. If I were older

3. Girls

4. My friends think

5. What makes me mad is

6. My father

7. I miss

8. I am scared

9. I often think of myself as

10. My only trouble

11. I dream of

12. Being younger would

13. I hate

14. If I don't get what I want at home

15. What worries me is

16. When I grow up

17. Nothing bothers me more than

18. Other people think I'm

19. I feel unhappy sometimes because

20. Boys

21. There are times when I

22. Being my age is

23. I don't think I can

24. It's tough when

25. At home

26. Teachers are

27. If I am left behind

28. Sometimes I think about

29. If I were smarter

30. Sometimes I fell like

31. It is more important to

32. I wonder if I should

33. My mother

34. If my parents had only

35. I would be happier if

36. I'm glad I am

37. I wish I were

38. If I could choose my family

39. If only I were not so

40. It would be funny if