

**Lydia Minear, MA, LPC**

Counselor

770.617.0253

lydiaminear@gmail.com

**Lydia Minear Counseling**

2655 Dallas Highway Suite 240

Marietta, GA 30064

www.lydiaminear.com

## **Informed Consent Adult 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. If you have any questions, your counselor will be happy to discuss them with you.

\_\_\_\_\_ (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. Please note that in couple's counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Your counselor will be discreet if it is necessary to contact you at home or at work. If you have a specific number that is best for contact please let your counselor know.

\_\_\_\_\_ (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.

**CONFIDENTIAL**

Page 1

\_\_\_\_\_ (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 above information and voluntarily request counseling services and I agree with these terms and conditions:**

Signature \_\_\_\_\_ Date \_\_\_\_\_

*\*The signature of the custodial parent or guardian is required for clients under 18 years of age.*

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 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/](http://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 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 your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

**CONFIDENTIAL ADULT INTAKE**

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Present Address:

\_\_\_\_\_  
Street / City/ State/ Zip

Home Phone: \_\_\_\_\_ May we call? Yes/ No Leave Messages? Yes/ No

Cell Phone: \_\_\_\_\_ May we call? Yes/No Leave Messages? Yes/No

Work Phone: \_\_\_\_\_ May we call? Yes/No Leave Messages? Yes/No

Email: \_\_\_\_\_ May we email? Yes/No

Referred by: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ (# of Years \_\_\_\_\_) Divorced \_\_\_\_\_ Separated \_\_\_\_\_

If married, spouse's name: \_\_\_\_\_

I have \_\_\_\_\_ (#) of children. Child's (children's) name(s): \_\_\_\_\_

Presently Living With: Parents \_\_\_\_\_ Spouse \_\_\_\_\_ Roommate \_\_\_\_\_ Alone \_\_\_\_\_ Other \_\_\_\_\_

Family member to notify in case of emergency: Name \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**VOCATION INFORMATION**

I am employed: Yes/ No I am employed with: \_\_\_\_\_

My title is: \_\_\_\_\_ Time employed: \_\_\_\_\_

My job has impacted by presenting concerns: Yes/No

If yes, how?

\_\_\_\_\_

**EDUCATION BACKGROUND**

I completed the \_\_\_\_\_ grade, or \_\_\_\_\_ years of college.

My experience of school was

\_\_\_\_\_

**FAMILY BACKGROUND**

My Primary Caregiver was: \_\_\_\_\_

Current marital status of parents (Circle one): Married / Divorced / Separated / Partnered / Single

Parent / Never Married / Widowed / Both Deceased

Relationship with Mother can be described as:  
\_\_\_\_\_

Relationship with Father can be described as:  
\_\_\_\_\_

I have Siblings: Yes/ No                      If yes, please list:  
\_\_\_\_\_

My childhood home was (circle one): Stable / Not Too Stable / Unstable / Other: \_\_\_\_\_

**RELIGIOUS/CULTURAL BACKGROUND**

Religious Affiliation: \_\_\_\_\_

My religious/cultural background has been an important factor in my life: Yes/No

If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Are you a member of a religious or spiritual organization? Yes / No

If yes, please name: \_\_\_\_\_

I am involved (circle one): Actively / Occasionally / Minimally / Not at all

**PHYSICAL/ MENTAL HEALTH CONCERNS**

Describe any physical problems you have that require medication or physical care:  
\_\_\_\_\_

Are you currently receiving medical treatment? Yes / No

Are you currently taking any prescription medications? Yes/ No

If yes, please list by name and dosage:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous counseling/therapy? Yes/ No      If yes, when?  
\_\_\_\_\_

With whom? Therapist/ Psychiatrist Name & Agency:  
\_\_\_\_\_  
\_\_\_\_\_

Please list any previous Mental Health Diagnosis received:  
\_\_\_\_\_  
\_\_\_\_\_

**PRESENTING CONCERNS**

Briefly describe the current problem for which you are seeking 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?  
\_\_\_\_\_  
\_\_\_\_\_

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
- \_\_\_ Depression
- \_\_\_ Education
- \_\_\_ Eating Difficulties
- \_\_\_ Fearfulness
- \_\_\_ Nervousness
- \_\_\_ Financial Problems
- \_\_\_ Marital Problems
- \_\_\_ Physical Problems
- \_\_\_ Problems with social relationships
- \_\_\_ Problems with children
- \_\_\_ Problems with parents
- \_\_\_ Religious/Spiritual Concerns
- \_\_\_ Sexual Concerns
- \_\_\_ Thoughts 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:

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. My Personality would be better if
9. I often felt that mother
10. My temper
11. My childhood
12. My biggest disappointment
13. To me, sex is
14. I would be better liked if
15. I often felt that father
16. My children (child) (brothers and sisters)
17. Women are
18. What hurts me most is
19. My biggest problem in life is
20. Men are