2018

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2018 **CONSENT FOR OUTPATIENT and/or RESIDENTIAL PSYCHOTHERAPY, and ART PSYCHOTHERAPY for MENTAL ILLNESS, TRAUMA and/or ADDICTION COUNSELING CONTRACT**

Success in counseling is a shared responsibility between the counselor and client, therefore, this information is provided to you to make clear the nature of our professional relationship. The counselor-client relationship differs from most other professional relationships, and as a result, agreement on the following is necessary for you to receive the most out of our work together.

In the state of California, Ericha Scott, PhD provides psychotherapy for individuals, couples, families or groups to remediate symptoms of distress. She is also dually certified and licensed as a chemical dependency counselor to work with chemically addicted adults, their family members, and significant others. Dr. Scott has met the California board of behavioral health's requirements, for those licensed as a professional clinical counselor, and has been granted an additional registration to provide marriage and family therapy. In the course of psychotherapy, an individual client may invite family members (considered to be collaterals by the board) to participate as a guest to the counseling session to help provide a cohesive history or description of the reason for the need for treatment. This practice is good quality standard of care. If Dr. Scott is initially sought to provide couples or family counseling, and it is determined that one or more members of the couple or family need individual sessions, she will refer the individual to another practitioner for individual treatment in order to protect the integrity of the couple/family therapy work in process,

Please note that if you are in residential treatment program, or if your treatment is managed by a professional agency, whether I am paid by the residential program/management team or by you personally, I am working as - a/or as if a - staff member of the treatment center team and therefore I provide regular clinical updates to their clinical team for quality care, continuity of care, and team cohesion.

PURPOSE OF TREATMENT: The purpose of treatment is to meet your individual, couple, family or group psychotherapy and/or addiction counseling goals, which will be outlined in the Treatment Plan (TP). Treatment Plans are reviewed at least once a year and you, the client, actively participate in creating and reviewing it. While in treatment for mental health, relational, trauma or addiction issues you agree to participate in individual, joint, couple, family and group sessions - as needed - related to your presenting problems and/or problems that reveal themselves in therapy over time.

I use a variety of counseling modalities, including but not limited to, traditional talk counseling (i.e., active listening, reflection, reframing, summarizing, confrontation, & intervention), guided imagery, experiential and creative arts processes (i.e. visual arts, poetry, lyrics for songs, acting/role play, psychodrama, sand play & journal writing), with attention to stress and emotions in the body as a potential trigger for relapse via substances or mental illness. As with any modality, there are benefits, limitations, and risks.

The focus of individual psychotherapy will be on issues that you identify upon admission such as mental illness, sadness, anxiety, grief and loss, and trauma. If you are requesting

treatment for addiction the focus will be related to the powerlessness and unmanageability of addiction and how to intervene and sustain long-term sobriety. Obviously, there is an overlap between psychotherapy and addiction treatment. Psychotherapy may include self-exploration, gaining insight which may provide relief, healthy expression of emotions, a review of cognitive defense mechanisms and distortions, triggers (possibly for grief, anxiety, depression, and/or compulsions), participation in self-help groups (methods for self-awareness and accountability such as, but not limited to, the 12-steps), spirituality/meditation practices, exploration of dysfunctional family systems, roles and trauma (which includes Adult Child of Alcoholics/ Addiction Counseling and Codependency), healthy communication skills, problem solving, healthy life-style, life management skills, psycho-education, aftercare planning, and referral. For those with a dual diagnosis, referrals will be made to a medical doctor, psychiatrist, or an ND who can help manage mental illness with psycho-pharmaceutical forms of interventions.

THE THERAPY PROCESS: **Possible Benefits for Both Psychotherapy and Addiction Counseling**: a better understanding of your goals and values: resolution of the specific concerns that brought you to counseling, relief from intra-psychic distress as you gain enhanced awareness and emotional understanding of yourself; a better sense of your identity; improvement in your relationships with others as you improve; reduction in presenting symptoms associated with mental illness, addiction and/or dysfunctional family roles or dynamics; greater ability to cope with stress and work through difficulties; improvement in work or school performance; a deeper connection to a spiritual practice of your choice; strengthened self-esteem, and an overall sense of well-being and success.

Working toward these benefits, however, requires significant effort on your part and may result in your experience of considerable discomfort. Change will sometimes be easy and swift, but more often it will be slow and frustrating. Remembering, processing and resolving your internal experiences and dynamics or significant life events can bring up strong feelings of anger, depression, fear, etc. and may result in changes that were not originally intended.

Limitations and Risks: no experience of change; feeling worse before feeling better; an increase in feelings such as grief, sadness, and anger especially early in psychotherapy and sobriety; feeling better but having increased conflicts with others as you do things differently in a more healthy manner, potential short-term or long-term separation from close friends and family members, relapse in mental illness symptoms or addiction.

Theory and Techniques: The foundation of my practice is built on the theories of Jungian and existential therapies, which includes a search for meaning (Victor Frankl). I include ego-state therapy, from the foundational perspective that a multiple ego-state phenomenon is normative, as defined by many but also, Richard Schwartz's Internal Family Systems, Eric Berne's Transactional Analysis and Fritz and Laura Perls's Gestalt Therapy. I incorporate an integrative multi-model approach (Arnold Lazarus, PhD), since individuals and their problems can be very idiosyncratic and even their ego-state structure may be very individualistic. Existential therapies do not have specific treatment techniques which means that I borrow techniques from several other disciplines. For example, the Post Modernists believe in leveling hierarchal power structures between the client and therapist, this may be handled by a therapist sharing portions of his or her personal narrative in a way that is not common with other theoretical perspectives, but with attention and focus to address the client's needs.

As part of my therapeutic practice, I use several techniques, including but not limited to, journal and poetry writing, creative and expressive arts psychotherapies, sand play therapy, cathartic work (emotive), meditation practices, guided imagery, a review of individual and family history, roles and dynamics (functional and dysfunctional) and story telling.

NOTE: the meaning of art images and symbols are idiosyncratic (personal) and are not commonly used effectively for assessment for mental illness or in a trial setting.

You, the client, have a right to question and/or refuse any counseling interventions, suggestions or directives.

CONFIDENTIALITY OVERVIEW AND CLIENT RIGHTS

This information you give me during a session is strictly confidential. It will not be divulged to anyone unless you have given me verbal and/or written permission, with the <u>following exceptions:</u>

- My services were sought or obtained to enable or aid anyone to commit or plan to commit a crime.
- I have reasonable cause to believe that you are in such a mental or emotional state as to be dangerous to yourself, another person, or the property of another unless we come to some resolution by the end of the session. The disclosure of this information is to prevent threatened harm and to maintain safety.
- I suspect or have evidence that a minor child (under 18) is currently the victim of abuse or neglect. Child abuse means a physical injury, other than accidental, inflicted on a child by an adult or other person, sexual assault, cruel punishment, or severe abandonment, and/or neglect.
- I suspect and/or have evidence of abuse, neglect, or abandonment of a dependent adult or an elder adult.
- I am ordered by a court of law or the Patriot Act to disclose information.
- Telephone conversations, emails, texts, and Skype (or any form of online or video communications) are not as confidential as one on one counseling in an office setting. Although my computer email data is encrypted, which helps protect your confidential information, confidentiality cannot be guaranteed to the same level as in a private office setting. Please note that you assume the risks of the use of these forms of communication. If you do not wish to use email, texts, or online video communication (such as Skype), then please let me know in writing. If there are technological difficulties with these forms of communication please call me on my cell at, 310-880-9761, or call my colleague Dr. Don Grant, 818-216-8778. In order to provide you with the best possible treatment experience, I participate in consultation and trainings with other professionals. Unless I obtain written authorization from you or there is an emergency situation, identification will be by circumstance, rather than by name. By signing this document you agree to be discussed or have your case and art work shown in case management, consultations, trainings, or lectures with other professionals who are also bound by laws of confidentiality. Your identification will be disguised.
- Dr. Scott does not need a consent to release confidential information to discuss your treatment plan updates and/or operations with professionals on your treatment team and/or staff at various treatment centers, especially if you reside there.
- I do not share personal social media pages such as Facebook with clients, where a friends list is established, unless the client has been out of a counseling relationship with this author for two to five years. You may be able to sign up for a professional page that does not allow screening, but this is not encouraged. Professional pages usually do not have an option to screen participants. If you access my social media via a fake identity this is potential cause for termination of our therapeutic relationship.

Initial Here_____

- If, by chance, we meet in public, this author will not approach you or act as if we know each other. This may look impolite, but this is to protect your confidentiality. If you choose to violate your own right to privacy and confidentiality and approach Dr. Scott to say hello, she will greet you. If she feels as if you are being too open about your relationship in a way that might cause you harm at a later date, she may choose to excuse herself from the conversation. This is not a form of rejection, but instead, caring and protection.
- I have read the Privacy and Office Policies of Dr. Scott listed in detail below, and a more current separate document.
- I have been informed of HIPAA laws of confidentiality, privacy, and privilege.

Please respect the confidentiality of others seen or met in the counseling office or sessions. If the confidentiality of other clients in the waiting room or group sessions, is not honored, this may be a justification for termination of our counseling arrangement.

NOTICE OF PRIVACY POLICIES HIPAA

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI (Private Health Care Information), which includes information that can be used to identify you that I've created or received about your past, present, of future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, and has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made, and I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to the PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also request a copy of this Notice from me.

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you are being treated by a psychiatrist, I can disclose your PHI to your psychiatrist to coordinate your care.

2. To obtain payment for treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For Example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided for you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For health care operations. I can disclose your PHI to operate my practice. For example I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure that I'm complying with applicable laws.

4. Other disclosures. I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think you would consent to such treatment if you were able to do so.

B. **Certain Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:**

1. When disclosure is required by federal, state, or local law: judicial, or administrative proceedings; or law proceedings; or law enforcement. For example, I may make a disclosure to an applicable official when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect or when ordered in a judicial of administrative proceeding.

2. For public health activities. For Example I may have to report information to the county coroner.

3. For health oversight activities. For example, I may have to provide information to assist the government when it conducts an investigation of inspection of a health care provider of organization.

Initial Here_____

4. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.

5. To avoid harm. In order to avoid a serious threat I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

6. For specific government purposes. I may disclose PSI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

7. For worker's compensation purposes. I may provide PHI in order to comply with worker's compensation laws.

8. Appointment reminders and health related benefits or services. I may use the PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

C. **Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

1. Disclosures to family, friends or others. I may provide your PHI to a family member, friend, of other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B. C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't already taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YUOR PHI

You have the following rights with respect to your PHI:

A. The Right to request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Choose How I Send PHI to You. You have a right to ask that I send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

Initial Here_____

C. The Right to See Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 15-30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will not charge you more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures I Have Made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will gather, create, and provide the list to you, and will bill accordingly, at the standard billing rate established of $250.00 an hour.

E. The Right to Correct of Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (a) correct and complete, (b) not created by me, (c) not allowed to be disclosed, or (d) not a part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial.

F. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

G. The Right to Get This Notice by E-mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

Initial Here_____

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. **PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES.** If you have any question about this notice or any complaints about my privacy practices above, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Ericha Scott, PhD, CADC-II, P.O. Box 6806, Malibu, CA 90264, (310) 880-9761, ehitchcockscott@me.com. **VII. EFFECTIVE DATE OF THIS NOTICE** - This legal notice went into effect on April 14, 2003.

VII. **CLIENT RECORDS**

You may obtain a summary of your records or the ability to review your records by writing a request and allowing time to schedule an appointment to review the records within five days, a summary to be written within ten days, and for copies to be made within 15 - 30 days depending upon the size of the file.

NOTE: The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records unless I believe that your seeing them would be emotionally and/or physically damaging, in which case I will be happy to send them to a mental health professional of your choice, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged fees for any professional time spent in responding to information requests.

OFFICE POLICIES:

FEES, PAYMENT, AND APPOINTMENTS

Fees and Length of Therapy • I agree to enter therapy with E. Hitchcock Scott, PhD, LPCC917 for either one hour which equals a 53 minute session, or one hour and a half which equals 80 minutes or 1:20 Hrs, or a two hour session which equals 106 minutes or 1:46 Hrs, or a three hour session which equals 159 minutes or 2:39 Hrs (equals 1, 1.5, 2, 3 Hrs) weekly, biweekly, or more sessions during the next _____ to seven years.

I, the client, agree to pay the standard professional fees charged which will be $350.00 for a standard 53minute session (1 Hr) and $525.00 for each 80 minute session (1.5 Hrs). Fees may be periodically adjusted and clients will be notified in advance of the adjustment. Brief professional services, including telephone conversations, are billed at $87.45 per 15 minutes, or any part thereof. "I, the

Initial Here_____

client, will make payment in cash or by check at the time of the therapy appointment, unless we have made other arrangements. I understand that I can leave therapy at any time and that I have no financial, legal, or moral obligation to complete the maximum number of sessions listed in this contract. I am contracting only to pay for completed therapy sessions and telephone time, or session(s) I miss without providing 48-hours notice in writing"_____. Dr. Scott recommends that you cancel sessions via email, not text or phone, for documentation, confidentiality and privacy reasons. Please let Dr. Scott know if you have a preference for telephone, text or email responses. For the purpose of booking or canceling sessions, the client agrees to waive any confidentiality and privacy protections.

ADDENDUM July 21, 2015: This therapist is not an expert witness for court testimony, therefore she will not voluntarily participate in any litigation of any kind, or custody dispute in which the client or patient and another individual, or entity, are parties. This therapist has a policy of not communicating with the patient/client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in a patient's legal matter. This therapist will generally not provide records or testimony unless compelled to do so. Should this therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a patient or client, the patient or client agrees to reimburse this therapist and/or her office for any time spent for preparation, travel, lodging, or other time in which this therapist has made him/herself available for such an appearance at therapist's usual and customary hourly rate of $350.00 an hour. Assessments and reports are billed at $350.00 per hour. Professional fees will be assessed at the rate of $350.00 per hour (even if you have a scholarship with Dr. Scott for psychotherapy), or any part thereof, for any services related to litigation, defense, or other court or case-related activities. Such activities include interviews, evaluations, research, reports, correspondence, testimony, communication with attorneys, travel, and on-site time. In case of overnight travel, the maximum professional daily rate will be $3,500.00 which does not include expenses. Incidental expenses for professional services, such as, but not limited to, cost of travel, lodging and meals, will be billed to the client or his or her attorney.

Date_____

Client's Signature and Date:_____

REVIEW OF OFFICE POLICIES:

- OFFICE HOURS: Tuesdays, Wednesdays and Fridays from 12:00 PM till 9:00 PM.
- PAYMENT OF SERVICE: You are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify me if any problem arises in your ability to make timely payments.
  $350.00 for 53 minute session, due upon date of service.
  $525.00 for 80 minute session, due upon date of service.
  Please have a check made out before session and arrive on time so we are able to spend the whole 53 or 80 minutes for our work. If you have been granted a scholarship due to need or a professional courtesy, I request that you do not share your discount with others. Doing so may result in the loss of the scholarship.
- INSURANCE REIMBURSEMENT: Clients who carry their own insurance will bill their own insurance. I do not bill insurance, nor do I accept payment from them. However, if

requested I will provide a super bill for each check, or a monthly billing statement for you to submit to your insurance company or use as a tax write off. Most insurance agencies will not reimburse for missed appointments. By signing this document you agree to billing via email. Periodically, there are times I grant financial grace or scholarship, it is the author's prerogative to give grace to a client or not depending upon your progress in counseling, need, or circumstance. Please note, if you request a full scholarship or weekly discounted rate, then you must provide the most recently filed tax return, the year prior, for consideration.

- SESSIONS GREATER THAN SCHEDULED: 53-60 minutes for an hour session or 80-90 minutes for an hour and thirty minute session will be prorated to the nearest quarter hour, unless other arrangements have been made.
- CANCELLATIONS: Missed appointments without 48 hours notice will be charged the full fee; messages can be left at ehitchcockscott@me.com, or 310-880-9761 - 24 hours a day. An email is best for documentation of the time of cancelation. Please avoid texts, as they are less secure. Insurance companies will not reimburse for missed appointments.
- TELEPHONE TIME: Standard fee listed above for telephone calls, consults, written reports, and travel. Telephone messages left for Dr. Scott at 310-880-976, after working hours (Tuesdays, Wednesdays and Fridays after five PM, or Mondays, Thursdays and Fridays), will be returned the next day. Weekend calls will be returned on Monday.
- Unpaid bills over 60 days due, will be forwarded to a collection agency.
- I am not a child custody or divorce expert; therefore, I do not offer expert witness services. In addition, I do not voluntarily provide expert witness testimony of any kind.
- EMERGENCY PROCEDURES: An emergency is an unexpected event that requires immediate attention and can be a threat to your health. If there is an emergency of any kind, personal or otherwise, please call 911. If you leave an emergency telephone message for Dr. Scott please say so in the message and I will return your call as soon as possible. If I have not called you back within sixty minutes or sufficient time to intervene upon the crisis (which ever comes first), and the emergency persists, and the emergency requires it, please call 911, or your physician or admit yourself to the nearest hospital for observation.

TRAUMA: Due to the nature of memory, especially trauma memories, whether explicit or implicit, absolute veracity cannot be determined to have happened or not by Dr. Scott. This is true, even without a history of psychosis. The Greek root for the word trauma means wound. In this case, the word wound may refer to childhood trauma, domestic violence, medical abuse, accidents, car wrecks, national or weather disasters, or any form of harm that results in a wound, whether psychological or physical. Physical verification of a felt sense or experience of early childhood trauma is not necessary for the success of treatment. Processing trauma, as internally experienced, can provide relief, and like many counseling processes and techniques, can also escalate symptoms before providing relief. This author will encourage you to explore all options, a variety of professional services and providers, as well as the pros and cons of trauma treatment and various levels of care, as you make sense of your history, internal world and integration.

H.6. Social Media

H.6.a. Virtual Professional Presence

In cases where counselors wish to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles are created to clearly distinguish between the two kinds of virtual presence.

H.6.b. Social Media as Part of Informed Consent

Counselors clearly explain to their clients, as part of the informed consent procedure, the benefits, limitations, and boundaries of the use of social media.

H.6.c. Client Virtual Presence

Counselors respect the privacy of their clients' presence on social media unless given consent to view such information.

H.6.d. Use of Public Social Media

Counselors take precautions to avoid disclosing confidential information through public social media.

I have read and understood these policies:

_____

Client Name and Date

TERMINATION

You have the right to terminate therapy with me at any time without any financial, legal, or moral obligations other than those you have already incurred. If you do not revoke your consent, your consent and releases of information will automatically expire one year after the last counseling session attended, unless otherwise specified.

As your counselor or consultant, I am able to end our professional relationship, if I believe it is in your best interest, and also for the following reasons: 1) When I believe that therapy or consultation is no longer beneficial to you, 2) When I believe another professional will better serve you. 3) Nonpayment of Fees one month past the date of receiving the billing statement, (unless special arrangements have been made in writing), 4) If you miss three sessions in succession without canceling within 48 hours notice range then our counseling relationship may be automatically terminated. 5) Ethical Conflicts, 6) If I determine after the first three sessions that I cannot help you, I will assist you in finding a professional qualified to better meet your needs. If I have a written consent, I will provide that professional with information they request. There may be other reasons later in treatment that a client is not making progress in Counseling or Consulting and if so, at that time, we will discuss together the possibility of termination and referral, but this author may need to make the final decision. Other reasons for termination may include 1) Counselor Illness, Retirement, Geographical Move, The Transfer of Ownership or Sell of the Practice, or Personal Problem 2) Your violation of the Confidentiality of Other Clients in the Counseling Practice of Dr. Scott. 3) If the client makes any threats implied or verbalized against the safety of this author, family members, colleagues, other clients, or pets, as well as threats, implied or otherwise, against personal property. Covert threats of violence may include arriving at my home residence, stalking of any kind (including the internet), bringing a weapon to the office, inquiry about whether I keep weapons at the office. 4) Acts of Violence, no matter how small.

Initial Here_____

Termination is an important part of the treatment process, regardless of how many sessions you have attended. You have a right to close in the most effective manner, so please advise me of your intent to leave counseling, instead of just not returning. Due to the fact that people tend to leave counseling just before a relapse or as painful patterns or trauma arise, if possible, please schedule three appointments for healthy communication, intervention, resolution, time to develop an aftercare plan and closure. Termination over the telephone is not advised and may block your ability to return to this practice.

If you have any questions about my practice, or if due to sudden illness or other problem I am incapacitated, please call Don Grant, PhD at 818-216-8778, Debra Mandel, PhD at 818-335-6309, or Steve Frankel, PhD, JD at 925-943-6175 and they will help you.

EMERGENCIES

The nature of this practice is that of outpatient private practice or independent contractor psychotherapy and addiction services. This assumes that all clients are self-responsible, e.g., functioning and not in need of day-to-day supervision, or they are living in a residential program under 24 hour staff supervision. I cannot assume responsibility for your day-to-day functioning as an inpatient hospital or a residential facility can. In case of emergency and I am not available, please call 911, and then leave me a message about the nature of your emergency. If you are living in a residential program and you do not feel safe, ask for staff help, and even if you live in residential care and do not feel adequately supported by staff do not hesitate to CALL 911.

As part of your self-care and healthy functioning, I support and encourage you to develop and use a support system outside of counseling that you can rely on when the need arises. I strongly recommend twelve-step program participation, a sponsor, and working the 12-steps or some form of personal growth via a social group. For a meeting close to you:

Alcoholics Anonymous (A.A.) www.aa.org/, 212-870-3400

Cocaine Anonymous (C.A.) www.ca.org, 800-347-8998

Narcotics Anonymous (N.A.) www.na.org, 818-773-9999

I also recommend Al-Anon, Adult Children of Alcoholics, Gamblers' Anonymous, Overeaters' Anonymous, Sex and Love Addiction Anonymous, and most programs in 12-step, depending upon your history.

If you need more online referrals please check out the referral and resource page at www.drerichascott.com.

COUNSELOR CREDENTIALS:

I have read this entire Consent for Treatment, which includes, but is not limited to, information regarding Dr. Scott's Fees, Exceptions to Confidentiality, Duty to Warn, Telecounseling/ Telehealth Consent, Counseling Limitations and Risks, Office Policies, Termination Policies, HIPAA Privacy Policies, and Intake Questions consisting of a total of 21 pages, and I understand and I agree to these arrangements. I also agree to meet all financial obligations that I incur in my treatment and to take care of all professional fees as described earlier in this document.

Initial Here_____

I request the professional counseling services of E. Hitchcock Scott, PhD, NCC, LPCC917, ATR-BC. In the state of California, Dr. Scott is a Licensed Professional Clinical Counselor and a Licensed Alcohol and Drug Counselor (LAADC - a non-governmental license). She is also a nationally certified counselor (NCC, by the NBCC), a board certified registered art therapist (by the ATCB), and a certified interfaith spiritual director (by Tacheria). She holds six licenses in four states, Arizona (LPC - active), New Mexico (LPC - retired), Texas (LCDC) and California (LAADC). Due to the fact that my office might be moved from room to room in a treatment center on a regular basis, a copy of my license will be shown to you our first session and anytime thereafter upon request by you. If you participate in counseling at my private practice office the license is on posted the wall as you enter the room.

Dr. Scott has 34 years or professional experience providing services to those with mental illness, character disorders, complex trauma, and chemical addictions. She has been trained by and worked with several renowned leaders in the field of addiction and mental health. Please see her web site for a more complete biography, blog and resume at www.drerichascott.com. In addition, I have been shown a copy of her license which is displayed on Dr. Scott's office wall and/or has been handed to me in session. I am aware that Dr. Scott's Consent to Treatment with Office Policies is posted on her web page, www.artspeaksoutloud.org, and on the front of her office door.

The first 3-5 counseling sessions are to gather a complete client list of problems and life history in order to determine whether or not this counseling arrangement is a good match for the needs of you, the client. If not, you will be given two or three referrals and/or returned to your referent for follow up care.

Consent for Treatment: I have read the 21 page document….

I (PRINT) _____authorize and request that E. Hitchcock Scott PhD, LPCC917 (Ericha), to carry out assessments, psychometric examinations, diagnostic procedures, referrals, and/or treatment which now or during the course of my care as a client are advisable.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment which is confirmed by my signature.

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

You may have a copy of this form. Please Complete: PRINT FULL NAME, MAILING ADDRESS, EMAIL, & PHONE NUMBER, SOCIAL SECURITY NUMBER, COPY OF DRIVER'S LICENSE OR ANOTHER FORM OF I.D.

Initial Here_____

Adult Client Information Sheet

Client's name: _____Date: _____

Address: _____

_____

City, State: _____ Zip: _____

Email:_____

Phone numbers ***with area code***

Home: ( ) -

Work: ( ) -

Cell: ( ) -

Permission to leave a message_____

Birth date: _____ Age: ____ Social Security Number: _____

(If client is under 18: Parent's name(s): _____

Employer: _____

Position: _____ For how long?_____

Your education: _____

Marital/relationship status: _____ Spouse/partner's name: _____

Initial Here_____

Spouse/partner's age and sex: _____ How long together? _____

Spouse/partner's education: _____ Spouse/partner's occupation:

_____ Names and ages of all children in the home:

Who referred you to E. Hitchcock Scott, PhD, LPCC917?_____

Who shall we contact in case of emergency? Name: _____

Phone ( )_____, Email:_____

Family History

Single _____ Married_____(1st/ 2nd/ 3rd)_____

Spouse's Name_____Spouse's BD _____

Separated_____Date of Separation_____Divorced_____(1st/ 2nd/ 3rd)

Date of Divorce_____

Living with Significant Other/Roommate_____

Children's Names_____ Ages

Children's Names_____ Ages

Children's Names_____ Ages

Siblings' Names_____ Ages

Siblings' Names_____ Ages

Siblings' Names_____ Ages

Parents' Names _____ Ages

Parents' Names _____ Ages

Initial Here_____

Religious Preference/Affiliation_____

Medical History

1) Personal Physician_____

Phone_____

Home Address _____

Current Medications and Dosages _____

Date of last Medical Exam_____

2) Personal Physician_____

Phone_____

Address _____

Current Medications and Dosages _____

Date of last Medical Exam_____

Current Non Prescription Drug Use _____Frequency of use_____

Do (or did) your parents use drugs/alcohol? _____

Which parent(s) ?_____

Which drugs?_____

Do (or did) your parents have a mental illness?_____

Which parent(s) ?_____

Initial Here_____

Diagnoses known or suspected by client?_____

Have you been in psychotherapy before?_____Dates_____

With whom and where?_____

With whom and where?_____

What brings you to therapy now?_____

What else would you like me to know?

_____

_____

_____

_____

_____

What would you like to achieve from therapy?_____

_____

_____

_____

Who referred you to me and why? Do you give this author permission to thank the referent in writing?

YES or No

_____

Initial Here_____

List all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

List all current or past health problems, and any major operations:

Current	Past

List all therapists you have seen, and dates you saw them:

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates:

Please indicate which of these substances you currently use:

Substance	Amount used	How many times per month do you use it?
❑Cigarettes		
❑Alcohol		
❑Marijuana		
❑Cocaine/crack		
❑Heroin		
❑Pills not prescribed for me		
❑Hallucinogens		
❑Other (please list):		

Initial Here_____

	I have this now	I had it in the past
Difficulty falling asleep or staying asleep	❑	❑
Sleeping too much	❑	❑
Change in appetite, weight loss, or weight gain	❑	❑
Frequent crying	❑	❑
Thoughts of killing or hurting myself	❑	❑
Attempts to kill or hurt myself	❑	❑
Problems concentrating	❑	❑
Periods of daily sadness lasting more than two weeks	❑	❑
Little or no interest in sex	❑	❑
I feel tired almost every day	❑	❑
Problems remembering things	❑	❑
Periods of time in which I felt so good or so hyper that other people thought I was not my usual self *or* I was so hyper that I got into trouble	❑	❑
I startle easily	❑	❑
Can't stop remembering upsetting past events	❑	❑
Difficulty controlling my temper	❑	❑
I physically hurt other people	❑	❑
I break things sometimes	❑	❑
I worry a lot	❑	❑
Panic attacks or anxiety attacks	❑	❑
Feeling that I or my surroundings are unreal	❑	❑
Made myself throw up in order to lose weight	❑	❑
Used laxatives or exercised excessively to lose weight	❑	❑
I often feel like I am an outsider	❑	❑
Sexual problems	❑	❑
Worry that something is wrong with my body	❑	❑
Frequent arguments with the people I live with	❑	❑

Initial Here_____

GAF

Code	Description of Functioning
91 - 100	Person has **no problems** OR has superior functioning in several areas OR is admired and sought after by others due to positive qualities
81 - 90	Person has **few or no symptoms**. Good functioning in several areas. No more than "everyday" problems or concerns.
71 - 80	Person has symptoms/problems, but they are **temporary, expectable reactions to stressors**. There is no more than slight impairment in any area of psychological functioning.
61 - 70	**Mild symptoms in one area** OR difficulty in one of the following: social, occupational, or school functioning. BUT, the person is generally functioning pretty well and has some meaningful interpersonal relationships.
51 - 60	**Moderate symptoms** OR moderate difficulty in one of the following: social, occupational, or school functioning.
41 - 50	**Serious symptoms** OR serious impairment in one of the following: social, occupational, or school functioning.
31 - 40	**Some impairment in reality testing** OR impairment in speech and communication OR serious impairment in several of the following: occupational or school functioning, interpersonal relationships, judgment, thinking, or mood.
21 - 30	**Presence of hallucinations or delusions which influence behavior** OR serious impairment in ability to communicate with others OR serious impairment in judgment OR inability to function in almost all areas.
11 - 20	There is **some danger of harm to self or others** OR occasional failure to maintain personal hygiene OR the person is virtually unable to communicate with others due to being incoherent or mute.
1 - 10	**Persistent danger of harming self or others** OR persistent inability to maintain personal hygiene OR person has made a serious attempt at suicide.

Initial Here_____

Initial Here_____