KellyJohnstonCounseling.com
Jaye@KellyJohnstonCounseling.com

Information, Authorization & Consent to Treatment

This document is intended to inform you about what you can expect from your practitioner, policies regarding confidentiality and emergencies, and other details regarding your sessions. This document is part of an ethical obligation to our profession as well as our commitment to keep you informed of every part of your therapeutic experience. Your relationship with your practitioner is a collaborative one; thus, we welcome any questions, comments, or suggestions regarding your sessions at any time.

Jaye Kelly-Johnston, LPC-S, CMS-CHT, FIBH, Licensed in the State of Texas as a Licensed Professional Counselor-Supervisor. NPI # 1881764702. A Fellow of the International Board of Hypnotherapy. Nationally Certified Medical Support Hypnotherapist from The Hypnotherapy Academy of American.

Professional Organizations:
Texas State Board of Examiners of Licensed Professional Counselors License # 15145
International Board of Hypnotherapy Certification number # F11017-514
American Association of Christian Counselors
American Counseling Association.
American Psychological Association.

Professional Counseling by law the practice of professional counseling is defined as the application of mental health, psychotherapeutic principles to facilitate human development and adjustment throughout the life span. Conduct assessments and evaluations to establish treatment goals and objectives; and plan, implement, and evaluate treatment plans.

Hypnotherapy is an educational and self-improvement process that facilitates access to a person's internal resources to assist him/her in solving problems, increasing motivation, or altering behavior patterns to create positive change. Hypnotherapy is not a substitute for medical treatment. Kelly-Johnston Counseling, PLLC does not practice medicine.

Medical Support Hypnotherapy is used only as an adjunct to conventional medical treatment. Consultation with a licensed physician is required before medical support hypnotherapy services are provided.

In Order To Be More Successful in Reaching My Goals, I Agree To:

- Be an active participant in my psychotherapy and or hypnotherapy experience and see myself as a partner in the transformative nature of this process.
- Recognize that my thoughts, feelings, images and actions have a direct effect on the quality of my life.
- Acknowledge that my well-being depends directly on how well I care for myself physically, emotionally, intellectually and spiritually.
- Accept that blaming others or myself is totally futile.
- Take responsibility for my experience of life, because I create my life experiences to the best of my ability in the moment, with what I know right now.
- I agree to be on time for sessions and allow **at least 24 hours** of advance notice should I need to cancel or reschedule a session @ 281-536-6503.

□ **By checking this box, I acknowledge that I have read and received the Limitations on Confidentiality.**

□ **By checking this box, I acknowledge that I have read and received the Basic Rights for All Clients form.**

□ **By checking this box, I acknowledge that I have read and received the Fees and Financial Policies form**

□ **By checking this box, I consent for services to be provided by Kelly-Johnston Counseling, PLLC.**

____ ____________________

Client / Parent / Guardian Signature Date

Complete HIPPA text available at www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/adminsimpregtext.pdf Provider credentials can be verified through the Texas State Board of Examiners of Professional Counselors. Complaints can be made by calling 1-800-942-5540 or contacting: Investigations, P.O. Box 141369, Austin, Texas 78714.

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Client Information Sheet

Client Name: ____ Date of Birth: ____/____/_____ Age: ___________

Parent Name for Minor:____

Address: ____

City, ___________________________________State____________Zip:______________

Phone Number:__________________________________ Can Leave Message: ☐ Yes ☐ No

Email: ____ Can Send Emails: ☐ Yes ☐ No

Referral Source: ____

Marital Status: Minor Single Married Divorce Separated Widowed

Military Service: ☐ Yes , branch:_____________________________________ ☐ No

Employer/School: ____

Emergency Contact: _____________________________________ Phone: _____________________

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Mental and Medical Health History page 1

What brought you to schedule services at this time?

____

____

What other information would you like to share that you believe would be helpful

____

____

Life Events: Please check any and all life events that you have experienced over the last 12 months:

☐ Death of a spouse	☐ Family member ill	☐ Foreclosed on mortgage	☐ Change of work hours
☐ Divorce	☐ Pregnancy of self/partner	☐ New work responsibilities	☐ New residence
☐ Marital separation	☐ Sexual difficulties	☐ Child leaving home	☐ Change of school
☐ Death of a close relative	☐ New addition to the family	☐ Trouble with in-laws	☐ Recreational change
☐ Personal injury or illness	☐ Change in finances	☐ Partner begins/stops work	☐ Church activity changed
☐ New marriage	☐ Death of a close friend	☐ Began/Finished school	☐ Social activities changed
☐ Fired from work	☐ New job	☐ Living conditions changed	☐ Change in sleep patterns
☐ Marital Problems	☐ Arguing with spouse	☐ Change of personal habits	☐ Change in eating habits

Childhood History:

Briefly describe your mother as you remember her in childhood:
Briefly describe your father as you remember him in childhood:

Presenting Symptoms: Please check any symptoms you have experienced over the last two weeks:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Suicidal Thoughts	☐	☐	☐	☐	Homicidal Thoughts	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Delusions	☐	☐	☐	☐
Feelings of Hopelessness	☐	☐	☐	☐	Obsessive Thoughts	☐	☐	☐	☐
Feelings of Worthlessness	☐	☐	☐	☐	Extreme Fears	☐	☐	☐	☐
Difficulty Concentrating	☐	☐	☐	☐	Hyperactivity	☐	☐	☐	☐
Lost Interest in Activities	☐	☐	☐	☐	Elevated Mood	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐	Racing Thoughts	☐	☐	☐	☐
Social Isolation	☐	☐	☐	☐	Feelings of Guilt	☐	☐	☐	☐
Sexual Dysfunction	☐	☐	☐	☐	Feeling Distracted	☐	☐	☐	☐
Change in Sleep Pattern	☐	☐	☐	☐	Anxious Thoughts	☐	☐	☐	☐
Appetite Loss/ Gain	☐	☐	☐	☐	Depressed Mood	☐	☐	☐	☐
Weight Loss/ Gain	☐	☐	☐	☐	Paranoia	☐	☐	☐	☐

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Mental and Medical Health History page 2

Date of your most recent physical examination: ______________________________________

Please list all current mediations and dosages:

Current Medications	Dosage (mg)	Frequency	Physician's Name

Please list all current or past physical health problems:

Current	Past:

Family History of Mental Health and/or Substance Use: (X all that apply)

	Mother	Father	Siblings	Self	Age started	Frequency of usage
Alcoholism						
Amphetamines						
Cocaine						
Heroin/Opiates						
Marijuana						
Anxiety						
Depression/ Mood D/O						
Eating Disorder						
Schizophrenia						
Suicide Attempt						

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Limitations on Confidentiality

All information regarding evaluation, diagnosis, observations, interactions, and treatment of a client is confidential information that this provider will disclose only to authorized people and agencies. The client and/or parent must provide prior written permission and authorization before any information will be released to another person, agency, or professional organization either verbally or in writing. Confidentiality and privacy of all client information will be maintained to the highest standards of the law and ethical practice.

The following are legally specified and required exceptions to the laws of confidentiality:

- If a counselor learns of child or elder abuse that is currently taking place or has the probability of recurring, he or she is legally required to report that abuse to the appropriate authorities.
- If a client discloses an intention to do something that is likely to harm him/herself or others, the counselor is required to report that intention to authorities.
- If a court order/subpoena, or other legal proceeding requires disclosure all records may be released.
- If the client enters into litigation against the therapist.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations implemented standards for how information that identifies a patient can be used and disclosed. (Title 45, Code of Federal Regulations (CFR), Parts 160 and 164) The regulations apply to "covered entities" including health-care plans, health-care clearinghouses, and health-care providers. These privacy standards went into effect on April 14, 2003.

In regards to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I have been made aware of how my medical information may be used and disclosed and how I can get access to this information.

I understand confidentiality and its limitations.

____ ___________________

Client / Parent / Guardian Signature Date

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Basic Rights for All Clients

- You have the right to impartial access to treatment regardless of race, religion, gender, age, ethnicity, or disability.
- You have the right to considerate and respectful treatment and recognition of your personal dignity.
- You have the right to a written statement of your rights.
- You have the right to be informed of your rights in a language you understand.
- You have the right to adequate, appropriate, and compassionate services regardless of financial ability.
- You have the right to services provided in the least restrictive environment possible.
- You have the right to participate in all treatment decisions
- You have the right to obtain information about treatment recommendations and alternatives.
- You have the right to obtain information about your condition and prognosis from your clinician.
- You have the right to a periodic review and update of your treatment plan.
- You have the right to be involved in referral or termination of treatment.
- You may terminate services at any time unless legally prohibited from doing so.
- You have the right to be informed of clinical alternatives available when you leave treatment with specific follow up recommendations distinctively outlined.
- You have the right to report any incidents of abuse or neglect, whether you are a victim or an observer. You will be provided with these contact phone numbers and addresses before the initial session.
- You have the right to expect that all communications and records pertaining to your treatment be treated as confidential, except as otherwise required by law.
- You have the right to be told of any experimental treatment approach recommended for you, and you must give your written consent before any such approach can be used.
- Patients, significant others, and staff have the right to have ethical issues that arise in treatment considered, discussed and dealt with in a clinically appropriate manner.
- You and your family/significant others, have the right to request a review of the practices and procedures for insuring patient's rights and for addressing questions or complaints about your individual treatment plan. 19. You have the right to be told in advance of all estimated charges being made, the cost of services provided, sources of the clinic's reimbursement, and any limitations on length of services known.
- You have the right to withdraw your permission at any time in matters to which you have previously consented.
- You have the right to request the opinion of another clinician or psychiatrist at your own expense.

I certify that I have received a copy of this document prior to treatment and I was given the opportunity to ask questions regarding my rights as a client. I understand that ethical boundaries exist between therapist and client. Mutual respect is required for a successful therapeutic relationship. Any situation that violates or blurs these boundaries will be discussed and may lead to a termination of the therapeutic relationship. This includes excessive and/or disrespectful use of electronic and telephone communication. As always, feedback is invited and if at any point questions arise regarding professional boundaries, the client holds the right to question this professional relationship.

____ ____________________

Client / Parent / Guardian Signature Date

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Social Media Policy (SMP)

Electronic communication and tools have become a fact of modern life. It is important to your confidentiality and privacy to understand how and when your therapist may use or be prohibited from using electronic communication and tools in conjunction with your care. This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to interactions that may occur between us on the Internet.

Social Networking Site: Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). the American Counseling Association have specific guidelines in their ethical codes regarding social media and clients; adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Following: I will not follow any client on Twitter, Instagram, blogs, or other apps/website. You are welcome to like my business Facebook Page, or follow the business on Instagram, in order to stay informed about upcoming events.

Email: Please use email to contact me for administrative reasons only (modifying appointments, billing information, etc.). Please do not email content related to our counseling sessions, unless otherwise discussed. Email communication is not completely secure or confidential. Any emails I receive from you and any responses I send to you become a part of your legal record.

Text Messages: Text messages are limited to issues regarding appointments. Please do not send text messages regarding anything discussed during sessions. I will not respond to such texting. Any text message I receive from you becomes a part of your record.

Search Engines: It is not a regular part of my practice to search for client information online through search engines such as Google or social media sites such as Facebook. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Location-Based Services: Please be aware if you use location-based services on your mobile phone you may compromise your privacy while attending session at my office. My office is not a check-in location on various sites such as Foursquare, however it can be found as a Google location. Enabled GPS tracking makes it possible for others to surmise you are a counseling client due to regular check-ins at my office location.

Business Review Sites: You may find Kelly-Johnston Counseling, PLLC on sites such as Yelp, Google, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. You have a right to express yourself on any site you wish. Please note that by posting publicly about your counselor or counselling experience, you may inadvertently expose your private information. We urge you to take your own privacy as seriously as we take the commitment of confidentiality.

Protecting your confidentiality means that as your counselor I cannot tell people that you are a client. But you are welcome to tell anyone you wish who your counselor is or how you feel about the treatment provided to you, in any forum of your choosing. But, please do not rate or review your counselor's work with you on any of the above-mentioned websites while you are still in treatment. Doing so has a significant potential to damage your ability to work together, and may jeopardize your own privacy.

By signing this form you agree to comply with the Social Media Policy (SMP) of Kelly-Johnston Counseling, PLLC.

____ __________________

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Audio Recordings

If we record a basic hypnosis session for you to listen to on your own, it is understood that this recording is for your personal use only. This recording is not for public consumption and should not be copied, shared, distributed, sold, posted online or disseminated in any form.

The audio recording can cause you to become relaxed and even sleepy. It should not be listened to in a vehicle, while operating heavy machinery or during any activity where alertness or attention are required for safety. Instead, listen to it at home in a safe comfortable environment – preferably while lying down. And give yourself plenty of time to return to a state of complete alertness afterward before returning to your normal activities.

There is no promise or guarantee made for specific results or outcomes. However, guided imagery, hypnosis and hypnotherapy can help you explore and resolve issues that may be bothering you. Your motivation and participation contribute greatly to achieving your desired outcome.

I have read and understand the information described above.

____ ___________________
Client / Parent / Guardian Signature Date

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Fees & Financial Policies

We recognize that our services often involve a serious financial investment for most people. We also believe that these services are a crucial investment in more fully becoming the person you were created to be.

At Kelly-Johnston Counseling, PLLC, first appointments are up to 75-minute in length aimed at building a relationship with you, clarifying the nature of your struggles, and exploring how we might work together to assist you. Subsequent sessions are up to 60 minutes in length.

Psychotherapy Fees
Initial appointment (up to 90 minutes): $225.00
Subsequent sessions (up to 60 minutes): $150.00

Hypnotherapy Fees
Initial appointment (up to 90 minutes): $225.00
Subsequent sessions (up to 60 minutes): $150.00
PLRT (up to 90 minutes) $225.00

All fees are due at time of service. A charge of $75.00 will be charged for any checks that do not clear the bank. All counseling fees are subject to review and/or change.

Cancellations/Reschedules/No Shows
Since we regard time as a precious gift from God and our sessions with you as a joint commitment to our work; Reschedules, No Shows or Cancelations with less than 24hours to session will be charged 100% of the fee of session.

Consultations
While all consultations are free, there will be a $50.00 charge for no-shows.

Insurance
Kelly-Johnston Counseling, PLLC does not participate in insurance plans or insurance panels. We believe that remaining outside of this system will help us to safeguard your privacy, enable us to focus more solely on providing the best services we can, and keep our administrative expenses down.

Self-Pay
We accept cash, checks, and credit cards at the time of service. All tele-video sessions must be paid in advance of session.

I consent to receive counseling/hypnotherapy sessions and agree to pay all fees in accordance with the terms set above.

____ __________________
Client / Parent / Guardian Signature Date

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Credit Card Authorization Form

All information will remain strictly confidential. Your credit card will be kept on file. Insurance companies require the copay at the time of service. Your credit card will be billed using a secure, HIPPA compliant software. “Reschedules” “No-Shows” and “Cancellations” with less than 24hours notice will be billed for the session. Please review “**Fees and Financial Policies**

Client Name: ____

Cardholder Name: ____

Address ____ City ___________, State______ Zip Code: ______

Credit Card Type: ________Visa, _______MasterCard, ________Discover, ________American Express

Card Number: ____ Expiration: ______________ Security Code: _____________

I authorize Kelly-Johnston Counseling, PLLC to charge the agreed amount to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Sign and Date Below:

____ ___________________

Signature Date

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To Sum It Up

- Confidentiality is a priority. For any reports, notes or conversations outside the office, I will need your written approval.

- Every client will have a credit card on file. “Reschedules” “Cancellations” and “No-Shows” will be billed the session fee.
  - I hate this too, but unfortunately, it’s necessary.
  - You have my email and cell phone number for this purpose.

- You have all the rights afforded to you under law and common decency. If you want therapy to take a different direction, you are the boss and free to say so If needed, I will provide professional referrals to the best of my knowledge and ability.

When Healing Matters