Milgrim & Associates, P.C.
12584 Darby Brook Court
Woodbridge, VA 22192

Informed Consent

Annetta Thomas, MA, MA, NCC, Resident in Counseling

I would like to thank you for seeking therapeutic services with me (Annetta Thomas). This document contains essential information regarding my professional services, best practices, and policies. It is imperative that you read this documentation carefully and compose any questions you may have so that we can discuss them during our initial session. When you sign this document, it will represent an agreement for me to provide you therapy.

I am a graduate of Marymount University, where I earned my Master of Arts degrees in Forensic Psychology and Clinical Mental Health Counseling. I am pursuing licensure as a Licensed Professional Counselor (LPC) in the state of Virginia. As a Resident in Counseling, I have provided clinical services and therapy for approximately five years under the supervision of licensed professionals. Milgrim & Associates P.C. is providing me an opportunity to practice as a Resident in Counseling under the supervision of Mr. Steven Milgrim, LPC, LSATP. He may be reached at (703) 499-9889.

Counseling/Theoretical Approach

My therapeutic approach is anchored in an integration of understanding how your past experiences have impacted your present situations, the healing aspects of telling your narrative, and finding solutions through meaningful interactions. I believe that in the process of identifying the internal problem(s) causing distress and developing an awareness of problem(s), you will become empowered to move forward on your journey to peace, wholeness, and a better quality of life. Through our work together, you will become the catalyst for the change you desire. For successful progress to be made, clients must be willing to pursue change outside of therapeutic environment.

Confidentiality

All communication becomes part of the therapy record, which is accessible to you upon written request. All communication with you is confidential with the following exceptions: (a) release of information had been provided, (b) it is determined that the you present a clear and present danger to yourself or others (including child or elder abuse), or (c) if court ordered to disclose information. Therapeutic relationships are intimate by nature. It is very important that professional boundaries are clearly established and consistently adhered to, beyond Milgrim & Associates P.C. For example, if I encounter a you in a public place, I will not acknowledge you unless you acknowledge me first and there will be no discussion of matters discussed in sessions. These strict boundaries help protect the mutual trust that is necessary for therapy to be effective. Social media communication with you is prohibited. I will not accept request to connect via social media outlets on any of my personal or professional accounts. You may follow blogs, read articles, and share resources posted on the Milgrim & Associates P.C. social media sites promoting mental health awareness. I will not breech confidentially by acknowledging a therapeutic relationship in-person and/or on social media. As a Resident in Counseling, I will participate in supervision with a licensed professional and other resident(s) to enhance my skills. These opportunities allow me to gain feedback about my performance and are not a reflection of my you. In instances of consultation or supervision, anonymity is maintained and no identifiable information will be disclosed.

Counseling Minors
In addition to exceptions mentioned above, children and/or adolescents under the age of 18 participating in treatment are granted confidentiality. While parents or guardians have a legal right to know what interventions are being used and cost associated with treatment, it is not conducive to the therapeutic relationship to disclose all information shared in confidence. Therefore, issues discussed and behaviors displayed are maintained as confidential. However, children and/or adolescents should be aware of how their parent(s) and/or legal guardian(s) may be involved in clinical treatment and may access records. If your child engages in serious risky behaviors that place him/her in immediate harm, you will be informed. Your child/adolescent will be encouraged and supported in the sharing of progress and/or concerns/issues in session(s).

Emergency Care
In the event of an emergency, please contact emergency services 9-1-1 and/or go to the nearest hospital emergency room. If your emergency occurs outside of normal business hours, please leave a brief voicemail and/or email and I will contact you to schedule a follow-up appointment.

Inclement Weather and Cancelations
In the case of inclement weather, I will contact you regarding your session. If roads are icy or more than three (3) inches of snow occurs, sessions will be cancelled. If you deem it too dangerous to travel due to weather, please contact me prior to your appointment to reschedule.

INFORMED CONSENT AGREEMENT

_____
Client(s) name in print

This day retain(s) Annetta Thomas, MA, MA, NCC, Resident in Counseling, to provide psychotherapy.

It is expressly understood that Annetta Thomas has not issued, and will not issue, any guarantee of cure or treatment effects or number of sessions necessary.

We, the undersigned therapist and client(s), have read discussed together, and fully understand this agreement and the stated policies and agree to honor these policies. The client(s) enter(s) into this agreement voluntarily with competency and understanding and knowledge of consequences.

Signature(s) of Client(s): _____ Date: _____

If the client is under 18 years of age: I hereby state that I am the natural parent and/or legal guardian of the minor client; therefore, I am authorized to make this request for, and give my consent to, the therapy services to be provided.

Signature of parent/guardian: _____ Date: _____

_____ Date: _____
Annetta Thomas, Resident in Counseling

HIPAA Privacy Notification

I have been provided a Notice of Privacy Practices that fully explains the uses and disclosures that Milgrim & Associates, P.C. will make with respect to my individually identifiable health information. I understand that I have the right to review the Notice before signing this consent. Milgrim & Associates, P.C. has afforded me sufficient time to review this Notice and has answered any questions that I have to my satisfaction. I also understand that Milgrim & Associates, P.C. cannot use or disclose my individually identifiable health information other than as specified on the Notice. I also understand, however, that Milgrim & Associates, P.C. reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it sends a copy of the revised notice to the address that I have provided.

Cellular Telephone Communication Notification

Milgrim & Associates, P.C. utilizes cellular telephone communication. Due to the nature of cellular telephone communication, telephone calls on cellular telephones are subject to the possibility of unintended disclosure. Therefore, calls made on cellular telephones cannot be considered secure. Milgrim & Associates, P.C. will not disclose Protected Health Information on cellular telephones unless specifically requested to do so by patients.

The following telephone numbers are cellular telephone numbers:

1. (571) 989-3437

I understand that telephone calls made to this telephone number are not secure. I may request at any time that telephone calls with Milgrim and Associates, P.C. be made from a secure land line. Milgrim & Associates, P.C. will comply with these requests at the earliest possible time.

Contact by Telephone and Messages

I authorize Milgrim & Associates, P.C. to leave messages on my home and/or cellular telephone regarding presence in treatment and appointments. I authorize Milgrim & Associates, P.C. to leave messages on my work telephone with the name of the provider and a request to return the call.

SESSION LENGTH

Initial sessions are 50-55 minutes in length. Subsequent sessions are 45 minutes in length. Groups are 1 hour in length. If you are late to your session, I will be glad to see you, but due to scheduling restrictions I cannot extend the length of your session.

CANCELLATION, DENIAL, AND FINANCIAL POLICY

You will be responsible for the full amount of each visit. Individual sessions will be charged at the rate of $80 per 45-minute session. When an appointment is scheduled that time has been set aside solely for you, therefore canceled and/or missed appointments will result in a **Missed Appointment fee of $60, except in cases of emergency.** After two (2) missed appointments, regardless of reasons given, Milgrim & Associates, P.C., reserve the right to charge a missed appointment fee and/or recommend possible case closure for multiple cancellations. This will be handled on a case by case basis. Milgrim & Associates, P.C. will be glad to provide time spent writing letters, reports, or making phone calls at the rate of $30 per 15 minutes. We do not accept checks over $50.

I understand that reasonable efforts will be made by Milgrim & Associates, P.C. to collect these fees from me. If it becomes necessary for Milgrim & Associates, P.C. to forward this account to a collection agency, I authorize my demographic and financial information to be released and agree to pay all collection agency fees, a 50% agency fee, court costs and attorney fees.

INTAKE BIOGRAPHICAL DATA

DEMOGRAPHIC INFORMATION

Name: _____ Date:_____

Address: _____

_____

Phone (Home)_____ (Work)_____

(Cell)_____ (Pager)_____

Date of Birth: _____ Age:_____ Gender:____

Marital Status: _____ Email:_____

Guardianship (Where applicable) _____

Family Members Age Sex Relationship

_____

_____

_____

_____

Employer or School: _____ Occupation or Grade_____
Referral Source:_____
Primary Care Physician:_____ Phone:_____
Date of last physical exam:_____
Emergency Contact:_____ Phone:_____
Relationship to Client:_____
Allergies:_____
Current or Chronic Medical Problems:_____
Current or Past Mental Health Treatment (Please Include Name of Providers, Approximate Dates of Treatment, and Diagnoses): _____
_____

Current Medications (Including name, dosage, name of prescribing physician)
_____

_____
Client/Guardian Signature

_____
Clinician Signature