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

Informed Consent – Sharlene Hamilton, Resident in Counseling

Thank you for choosing this practice and my services. I realize that beginning psychotherapy is a major decision and you may have many questions. This document is intended to inform you of my policies, state and federal laws, your rights, and the nature of our professional relationship. If you have other questions or concerns, please do not hesitate to ask.

I am a graduate of Argosy University where I completed my Master of Arts in Clinical Mental Health Counseling. I am pursuing licensure as a Licensed Professional Counselor (LPC) in the state of Virginia. Milgrim and Associates is providing me the opportunity to practice as a Resident in Counseling under the supervision of Mr. Steven Milgrim, LPC, a Licensed Professional Counselor. He may be reached at (703) 499-9889.

Counseling Services Offered/Theoretical Approaches
Through individual psychotherapy, I ascribe to a holistic approach, integrating theories of psychology that address the mind and body. In particular, I encourage the client to reflect on past experiences, identify current struggles, become aware of cognitive, behavioral, and relational patterns and psychosomatic reactions, and develop desired goals and treatment strategies. I fully engage the client in a collaborative effort, empowering them as they recognize and build upon their own strengths and find meaning in their struggles. Along the way, the client is offered psycho-educational resources and instruction, practical skills, and manageable short-term goals. I view therapy sessions as a valuable time of self-discovery, healing, and growth.

Benefits and Risks
As with any intervention, there are both benefits and risks. Under professional discretion, all reasonable care and consideration will be taken to guard the client and this professional relationship from harm and danger. Understand that this process will require hard work on the part of the client and therapist. The client may experience uncomfortable levels of sadness, anxiety, guilt, anger, or other emotions. At times, the client may experience a worsening of circumstances as self-exploration and changes occur. The client is always encouraged to address these concerns as we move toward restoration and healthy adaptive functioning. Psychotherapy often ultimately leads to a significant reduction in feelings of distress, increased satisfaction in personal relationships, greater personal awareness and insights, increased skills for management of stress, and resolutions to specific problems. Each individual is unique and there are no guarantees of outcome.

Therapy is voluntary for the client, with freedom to continue, alter, or discontinue services at any time. I recommend that clients commit to a minimum of six sessions. If at any point I feel that the client would be better served by a specialized referral service, I will discuss this with the client and provide supportive care in the transition to these treatments.

Confidentiality
Privacy and confidentiality are imperative to effective treatment and the client-therapist relationship. Your records and personal information are protected by state and federal law and my professional ethics. In the event that I require professional consultation in regard to your treatment, I will disclose only that information which is necessary for accurate advisement with professionals, such as my

supervisor Steven Milgrim, who is bound by the same professional ethics and legal requirements. Confidentiality is limited within the following conditions: 1) I believe you intend to harm yourself or another person, 2) I am ordered by the court to disclose information, 3) you direct me to release your information, 4) pertinent information required by 3rd party payers.

If there is an emergency during treatment where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others, and to ensure that you receive the proper medical care. For this purpose, I may contact the police, the hospital, the targeted victim, and/or the person whose name you have provided as an emergency contact.

If I suspect that abuse of a child or elder may have taken place, I am required to report the suspected abuse to child or adult protective services. Abuse that happened in your childhood prior to becoming an adult at the age of 18 is not reportable unless there is a child who is currently in danger of being abused by the same person or persons. Child abuse includes physical or sexual abuse, neglect, excessive corporal punishment, child abduction and exposure to domestic violence that is traumatizing to the child. Elder abuse includes physical or sexual abuse, neglect, abduction, financial abuse, self neglect, isolating the elder, and not providing proper care, including medical care and mental health needs.

If you request couples or family therapy, couples and family members may be seen at times individually or conjointly. Information shared during these sessions or in related settings (e.g., telephone calls) is considered part of the overall family or couple therapy process and is not confidential from the other participating family members or partners. Bear in mind that "secrets" withheld from partners and/or family members can be counterproductive to the therapeutic process.

Counseling Minors

While parents or guardians have a legal right to know what treatment modalities are being utilized and what charges are incurred during the course of therapy with their child, it is not conducive to the therapeutic relationship, or in the child's best interest, to disclose all information that the child may share in confidence. Any information that is relayed to me by a minor within the counseling setting may be with-held from or disclosed to parents/guardians if, in my professional judgment, it is appropriate or necessary.

Explanation of Multiple Relationships

Therapeutic discussion involves intimate client disclosure. It is not unusual for a client to desire a more personal or social relationship with their therapist. However, in order to maintain appropriate and effective therapeutic treatment, our interactions will be limited to these professional sessions.

Internet and Social Media

Internet Searches: While my present or potential clients might conduct online searches about the practice and/or me, I do not search my clients with Google, Facebook, or other search engines unless there is a clinical need to do so, as in the case of a crisis or to assure your physical well-being. If clients ask me to conduct such searches or review their websites or profiles and I deem that it might be helpful, I will consider it on a case by case basis and only after discussing possible impacts to our professional relationship and your privacy.

Friending: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that 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. If you have questions about this, please bring them up when we meet and we can talk more about it.

Emergency Contact Instructions

In the event of an emergency and I am unavailable to take your call or respond within an hour, contact 9-1-1, contact or visit your local mental health crisis center, or go to the nearest hospital emergency room. Also, contact pre-selected family members or reliable friends to assist you with your situation, including your mental state and transportation.

Inclement Weather and Cancelations

In the case of inclement weather, and Prince William County Schools (PWCS) close due to the weather, I will not be holding sessions. 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) Sharlene Hamilton, Resident in Counseling, to provide psychotherapy.

It is expressly understood that Sharlene Hamilton 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 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:_____

Sharlene Hamilton, Resident in Counseling

HIPAA Privacy Notification

I have been provided a Notice of Privacy Practices that fully explains the uses and disclosures that Milgrim and 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 and 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 and 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 and 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 and 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 can not be considered secure. Milgrim and 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) 989-2198

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 and Associates, P.C. will comply with these requests at the earliest possible time.

Contact by Telephone and Messages

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

_____

Patient Signature Printed Name Date

THERAPY AGREEMENT

In order to make our relationship a successful one, please review the following information and ask any questions that you may have at this time.

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 can not 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 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 and 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 and Associates, P.C. to collect these fees from me. In the event that it becomes necessary for Milgrim and 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 .

CERTIFICATION AND AUTHORIZATION

I certify that the above information is correct. I authorize the release of any medical information necessary to process insurance claims. I request that payments be made directly to Milgrim & Associates, P.C. on my behalf. Therefore my signature will be on file with my insurance company.

SIGNATURE:_____ DATE:_____

INTAKE BIOGRAPHICAL DATA

DEMOGRAPHIC INFORMATION

Name:_____ Date:_____

Address: _____

_____

Phone (Home)_____ (Work)_____

(Cell)_____ (Pager)_____

Date of Birth:_____ Age:_____ Gender:____

Social Security #_____ Marital Status:_____

Email:_____

Guardianship (Where applicable)_____

Family Members:

Name 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)

_____

Developmental History ***Adults complete about self if information is known***

Was pregnancy normal? YES NO Explain_____
Was birth premature? YES NO Explain_____
Birth weight normal? YES NO Explain_____
Any use of alcohol, tobacco, or other drugs during pregnancy?
YES NO Explain_____

Born addicted? YES NO Explain_____
Require care in neonatal intensive care unit ?
YES NO Explain_____
Routinely followed by a pediatrician for first five years?
YES NO
Any congenital defects, speech, vision or hearing difficulties?
YES NO Explain_____
Growth and development occur within normal time frames?
YES NO Explain_____
Begin school as scheduled? YES NO Explain_____
Ever held back? YES NO Explain_____
Learning disabilities (IEP)? YES NO Explain_____
Diagnosed with ADHD? YES NO Age_____
Tendency towards violence towards self/others/animals?
YES NO Explain_____

_____
Client/Guardian Signature

_____
Clinician Signature