Milgrim and Associates, P.C.

12584 Darby Brook Court

Woodbridge, VA 22192

Informed Consent

Karen Trivett, LPC, MAEd.

Thank you for choosing this practice and my services. Please read this document carefully. It is intended to inform you of my professional services, best practices, and policies, and the nature of our professional relationship. If you have any questions or concerns, please do not hesitate to ask.

I am a 2006 graduate of Virginia Polytechnic Institute and State University, where I earned my Master of Arts in Education, Counselor Education. I am a Licensed Professional Counselor (LPC) in the state of Virginia. I have provided clinical services, and intensive in-home therapy to children and adolescents and their families for approximately 9 years while under the supervision of licensed professionals. I work under the supervision of Mr. Steven Milgrim, LPC, LSATP. He may be reached at (703) 499-9889.

Counseling and Theoretical Approach

I am a Licensed Professional Counselor with 13 years of experience working in the helping field. I work with children, adults, and families, with a focus on strength based, person centered techniques that emphasize self-esteem, positive thinking, and personal resilience. I have a great deal of experience with the school system and families experiencing behavioral challenges, emotional disturbance, learning disabilities, as well as AD/HD. My experience with adults and families includes mindfulness based treatments, assisting with stress management, and successfully navigating the growing demands placed on families today.

Confidentiality

Privacy and confidentiality are imperative to the effective treatment and the client-therapist relationship. Your records and personal information are protected by state and federal law and my professional ethics. As I may require professional consultation in regard to your treatment, I may disclose information which is necessary for optimal treatment with my supervisor, Steven Milgrim, LPC, LSATP, who is bound by the same professional ethics and legal requirements, and to other professionals, as recommended by my supervisor. 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 I suspect abuse of a child or elder, I am required to report the suspected abuse to Child or Adult Protective Services.

Counseling Minors

Custodial parents and legal guardians have a legal right to know what treatment modalities are being utilized and what charges are incurred during therapy with their child. However, it is not always conducive to the therapeutic relationship, or in the child's best interest, to disclose all information that the child may share in confidence. The amount of information to be shared with parents and guardians is at the discretion of the counselor. Your child/adolescent will be encouraged and supported in the sharing of progress and /or concerns/issues in sessions.

Emergency Care

If an emergency occurs outside of normal business hours, please call my cell phone 703-309-3906 and leave a brief voicemail and I will contact you as soon as possible. If you cannot wait, please contact emergency services at 9-1-1 and/or go to the nearest hospital emergency room.

Inclement Weather and Cancellations

In the case of inclement weather, I will contact you regarding your session. If roads are icy or more than 3 inches of snow occurs, sessions will be canceled. If you deem it too dangerous to travel due to weather, please contact me prior to your appointment to reschedule. There will be no charge for appointments canceled due to inclement weather.

INFORMED CONSENT AGREEMENT

Client's printed name:

This day retain(s) Karen Trivett, Licensed Professional Counselor, to provide psychotherapy. It is expressly understood that Karen Trivett has not issued, and will not issue, any guarantee of cure or treatment effects or number of sessions.

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 _____

Karen Trivett, LPC, MAEd.

HIPAA Privacy Notification

I have been provided a Notice of Privacy Practices that fully explains the uses and disclosure 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 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) of it sends a copy of the revised notice to the address that I 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. 703-309-3906

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 a 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 each visit. Individual sessions will be charged at the rate of $90.00 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 $50.00.

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 & Associate, 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) _____

Date of Birth: _____ Age: _____ Gender: _____

Marital Status: _____ E-mail: _____

Guardianship (Where applicable) _____

Family Members Age Sex Relationship

_____

_____

_____

_____

Employer of School: _____ Occupation/Grade _____

Referral Source: _____

Primary Care Physician _____ Phone: _____ Date of last physical exam:_____

Emergency Contact: _____Relationship to client: _____Phone: _____

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:_____ Date:_____

Clinician Signature:_____ Date:_____
