Milgrim and Associates, P.C.
12584 Darby Brook Court
Woodbridge, VA 22192
(703) 499-9889

Informed Consent – Nicole Ronayne, 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 attended The George Washington University and graduated with a Master's Degree in Clinical Mental Health Counseling. I am currently a Resident in Counseling and am working towards licensure as a Licensed Professional Counselor in the state of Virginia, under the supervision of Mr. Steven Milgrim, LPC, LSAPT. Mr. Milgrim can be reached at (703) 499-9889.

Counselor/Theoretical Approaches

My approach to counseling is based in psychodynamic theory, however, I integrate a variety of techniques from other theories/models in order to fit your needs.

Client Responsibilities

I understand that behavioral health care is a cooperative process, and I agree that I will attend sessions regularly, share openly and honestly with the provider, and make my wishes regarding treatment known. I am aware that behavioral health treatment may temporarily intensify my symptoms, and I agree to inform the provider of any changes that may occur. I further understand that I have the right to decline any services offered or suggested to me by the provider, and I may terminate treatment at any time. I agree to discuss termination of treatment with the provider prior to discontinuing treatment, as premature termination of treatment may have adverse effects.

Session Length

Initial sessions are 50-55 in length. Subsequent follow up 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 I cannot extend the length of your session. I also request that you notify me by phone, text message, or email if you are going to be late to a session.

Cancellation, Termination, and Financial Policy

You will be responsible for the full payment amount for each visit. Individual sessions will be charged at the rate of $80.00 per 45 minute session. **When an appointment is scheduled, that time has been solely set aside for you, therefore canceled and/or missed appointments will result in a missed appointment fee of $60.00, 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 termination of services and case closure. Milgrim & Associates, P.C. will be glad to provide time spent writing letters, reports, or making phone calls at the rate of $20.00 per 15 minutes. Accepted forms of payment include credit/debit, cash, and checks $50 dollars or less.

I understand that reasonable efforts will be made by Milgrim and Associates, P.C. to collect these

fees from me. In the even 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/Authorization
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.

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 Mr. Steven Milgrim, LPC, LSAPT who is bound by the same professional ethics and legal requirements. Confidentiality is limited within the following conditions:

1) I believe you have the intent to harm yourself or another person
2) Evidence to indicate abuse or neglect of a child, elder, or vulnerable adult
3) I am ordered by the court to disclose information
4) You direct me in written format to release your information
5) Pertinent information required by 3rd party payers

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.

Counseling Minors
While parents or guardians have a legal right to know what treatment modalities are being used 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 withheld from or disclosed to parents/guardians if, in my professional judgment, it is appropriate or necessary.

Social Media
Friending: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc).

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.

Inclement Weather and Cancelations
In the case of inclement weather, I will contact you regarding your session. If roads are icy or if snow fall (or expected snow fall) negatively impacts road conditions sessions will be canceled. 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) Nicole Ronayne, Resident in Counseling, to provide psychotherapy.

It is expressly understood that Nicole Ronayne 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**
(If required)

____

Nicole Ronayne, Resident in Counseling **Date**

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.

____

Client Signature **Printed Name** **Date**

____

Signature of Parent/Guardian **Date**
(If required)

Cellular Telephone Communication Notification

(Please initial in the line provided to indicate your understanding/authorization)

Milgrim and Associates, P.C. uses cellular telephone communication, however, calls made on cellular telephones cannot 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. (205) 541-8380

______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.

____

Client Signature **Printed Name** **Date**

____

Signature of Parent/Guardian **Date**
(If required)

INTAKE BIOGRAPHICAL DATA

Demographic Information

Name:____ Date:______________________

Referral Source: ____

Address: ____

____

Phone (Home)_______________________ (Work)___________________________________

(Cell)________________________

Email:____

Date of Birth:________ Age:_______ Gender:____ Marital Status:___________

Social Security Number:___________________________________

Guardianship (Where applicable)____________________________

Family Members: (Name, Age, Sex, Relationship)

____

____

____

____

Emergency Contact:___________________________________ Phone:_____________

Relationship to Client:________________________________

Education/Employment

Employer or
School:_______________________________Occupation:_____________________________

Are you employed full time or part-time?____

Are you satisfied with your current job:____

Comments:____

Highest level of completed education:__________________

Are you currently or have you served in the military: YES/NO

Medical/Mental Health Treatment History

Primary Care Physician:_______________________________ Phone:____________

Date of last physical exam:_________ Date of last dental exam:___________

Have you ever been diagnosed with a Vitamin D Deficiency:______________________

Allergies:____

Current or Chronic Medical Problems:____

Any history of seizures or epilepsy? YES/NO

Have you ever had a brain injury? Concussions/Contusions? YES/NO
Explain:____

Are you having any problems with eating, dressing, bathing, hygiene, or using the bathroom?
YES/NO Explain____

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, reason for

taking):____
____
____

(Females Only) Are you currently pregnant or plan to be become pregnant: YES/NO

Developmental History

(Adults complete about self if known)

Where there any complications during your mother's pregnancy with you or surrounding your birth? YES / NO Comments:_________________________________

Was birth premature? YES / NO Comments:_________________________________

Any use of alcohol, tobacco, or other drugs during mother's pregnancy?
YES / NO Comments:_________________________________

Born addicted? YES / NO Comments_________________________________

Require care in neonatal intensive care unit?
YES / NO Comments:_________________________________

Routinely followed by a pediatrician for first five years?
YES / NO Comments:_________________________________

Any congenital defects, speech, vision or hearing difficulties?
YES / NO Comments:_________________________________

Did you meet developmental milestones within normal time frames?
YES / NO Comments:_________________________________

Any history of bed wetting? YES / NO Comments:_________________________________

Begin school as scheduled? YES / NO Comments:_________________________________

Ever held back in school? YES / NO Comments:_________________________________

Learning disabilities (IEP)? YES / NO Comments:_________________________________

Diagnosed with ADHD? YES / NO Age:______

Did you receive treatment/medication? Comments:_____________________________

Tendency towards violence towards self/others/animals/fire setting?
YES / NO Comments_________________________________

____

Client Signature **Date**

____

Parent/Guardian Signature **Date**
(If required)

____

Clinician Signature **Date**