Virginia L. Monk, M.Ed. LPC-S
Licensed Professional Counselor and Supervisor
4211 I-40 West, Suite 101
Amarillo, Texas 7910609

Phone: (806) 350-5861 www.amarillofamilyinstitute.com **Fax: (806) 358-4345**

IMPORTANT INFORMATION AND CLIENT CONSENT

Please read and sign at the end stating you have fully read and understand the information below.

GENERAL INFORMATION

My name is Virginia L. (Ginny) Monk and I have a Master's Degree in Education and am a Licensed Professional Counselor in the State of Texas which allows me to provide individual, couple, family and group therapy. As one of the founders of *Restoration Therapy* many treatment plans are available to you. Our therapists also facilitate Marital Intensive groups of 4 couples in 4-day Intensives at www.thehideawayexperience.com.

I work with adults, couples, and families from across the lifespan dealing with various issues in their lives. Although I am capable of handling a variety of problems, there may be situations in which I will recommend you to another specialized therapist so you will be better served. Please note that I am not a Psychiatrist, (who is a medically trained doctor), so I am unable to prescribe medication. Also, I am not a Licensed Psychologist and I am unable to administer certain diagnostic tests.

My approach is an empathetic talk therapy that incorporates multiple therapeutic interventions such as Family Systems, Marital (if married), and Individuals, with emphasis in Cognitive/Behavioral, Solution Focused, Emotion Focused, and Restoration Therapy Modalities.

APPOINTMENTS

Your first initial visit will be an assessment session in which you and I will determine your concerns, and if we both decide that I can provide your therapeutic needs, then we will work on treatment objectives together. Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate. Group sessions are approximately 90 minutes long. If you must cancel or reschedule your appointment, please call my office at 806.350.5861 as soon as possible. _____ A**ppointments that are not cancelled at least 24 hours in advance must be charged to your account**. During times of crisis or containment we are agreeing to meet in virtual reality via Zoom or some other platform that is deemed necessary.

Due to the confidentiality policy, excluding minors, we are unable to schedule, confirm, adjust or cancel an appointment from anyone other than the client being seen unless a signed release is on file. If you and your spouse/partner are being seen together for the indicated session, it is acceptable for one party to schedule, confirm, adjust, or cancel an appointment. However, we will not notify the spouse/partner of the appointment change. In the event of a family or medical emergency a note will be made on the account without disclosing to a third party or family member unless a release is on file. _____

The initial Assessment Session is $175.00 for the first hour. Additional sessions are $150.00 per 50-minute sessions. There may be other fees assessed for separate profiles or educational materials. Most insurance companies will NOT reimburse for marriage or family therapy. I am also "out-of-network with most companies. We are, however, happy to file insurance claims for you upon full payment of services at each session in our office. I do not charge for time spent on case notes; however, Progress Summaries and telephone consultations are billed @ 37.50 in 15-minute increments. Virtual sessions via Zoom require a Credit Card on file. _____

Full payment of fees is expected at the beginning of each appointment. Subsequent sessions will then be scheduled at the conclusion of that session as determined by the participants. By signing this agreement, you understand that you are fully responsible for all fees. _____

LITIGATION
In unusual cases you may become involved in litigation that may require my participation. You are agreeing to reimburse our clinical professional fees of $800.00 for ½ day (4 hours) and/or $1600.00 for a full day (8 hours). Travel time is charged at $100.00 per hour and/or $25.00 for every 15 minutes of travel time. This is due in advance of the court date and or upon service of a subpoena. _____

RISKS/BENEFITS
Therapy can be beneficial to those that seek assistance, but as with any treatment, there are inherent risks. Therapy is designed to assist clients in resolving issues and to deal with painful life problems. I will make every effort to make therapy successful in this manner. However, you should know that there is no guarantee that you will solve your problems or that all of your issues with be resolved. During counseling we will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness or even more distress. If distress surfaces, please let me know. _____

Participation in therapy means that you accept these risks and are willing to deal with the potential problems that could arise. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course, but it is my desire, however, to work with you to attain your personal goals for counseling. _____

It is agreed that the client shall make a good-faith effort at personal growth and engage in the therapeutic process as an important priority at this time in his/her life. Suspension, termination, or referral shall be discussed for lack of commitment or for any unresolved conflict or impasse between counselor and client as soon as possible. _____

MINORS are seen by Melinda Zelman, LPC Associate, Jessica Romero, LPC Associate, or Jonathan McLoughlin, LPC Associate in my office.
Minors must have parental consent for counseling with the exception that the client is:

- 16 years of age or older and resides apart from the parents/guardians and manages his/her own financial affairs
- Thinking about suicide
- Concerned about alcohol or drug addiction/dependency
- Being sexually, physically, or emotionally abused.

Consenting parents have the right to examine the treatment records of children under the age of 18.
In order that minors may have the trust of a protected environment, it is your therapist's practice to ask the parents to forego that right (progress with the parent/guardian may be discussed) with the exception of extreme circumstances (see confidentiality). If divorce is proceeding the Divorce Decree will be provided before therapy begins. _____

At the termination of treatment and upon request, your therapist will provide the parent(s)/guardian(s) with a summary of treatment. It is important to note that in the state of Texas children under 17 may not have consensual sex (by law it is considered indecency with a child and therefore child abuse) and the state of Texas requires a therapist to breach confidentiality and report such activity to Child Protective Services (CPS). If your therapist is required to make such a report to CPS about your child, you will be informed as well. _____

CONFIDENTIALITY OF ALL ELECTRONIC COMMUNICATIONS

This includes but is not limited to the following: Email, Skype, Zoom (or any other face time service), chat, mobile devices, cell phones or fax. Please know that our office will maintain your confidentiality to the best of our ability; however, we **cannot guarantee this with any electronic communication**. If you choose to email me from your personal email account, please limit the contents to schedule changes or generic questions. Please know you may be charged applicable fees for a session. _____

In the event you are contacted or place a call to our staff, please be aware that unless we are both on landline phones, the conversation is not considered confidential and it is possible that your PHI/ePHI could be exposed. Likewise, text messages are not confidential and it is not advised or appropriate to converse about personal issues via text. Face to face sessions are for this purpose. I will make every effort to keep all information confidential. Likewise, it is important that you carefully determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors, and friends. Please only communicate through a computer that you know is safe, i.e. wherein confidentiality can be ensured. _____

DUAL RELATIONSHIPS/SOCIAL NETWORKING

_____Not all dual relationships are unethical or avoidable. Dual relationship situations might impair your therapist's objectivity, clinical judgment, or therapeutic effectiveness, thus will not be encouraged. If our paths should cross in public, **I will not acknowledge you unless you initiate contact.** It is preferred that you decide whether or not to disclose your acquaintance (with the therapist) to others. I do work broadly with families in family therapy.

_____Please be aware that social networking sites are utilized as a "blog" and not intended to replace personal therapy sessions. In regards to your therapist's personal social networking sites, **your therapist may choose not to accept your invitation in the interest of protecting your privacy.**

RELEASE OF INFORMATION

_____If information needs to be released it will only be done according to state law and with a written consent (separate form) from the client indicating an informed consent of such release. In the case of marital therapy, the client is the couple, not individuals; therefore, all records can only be released when **both parties** consent in writing or if mandated by the court.

INCAPACITY OR DEATH

_____In the event of the incapacitation or death of myself, it will be necessary to assign your case to another therapist and for that therapist to have possession of your treatment records. By your signature on this form, you are consenting to another LPC/ LPC-Supervisor, LMFT/LMFT Supervisor, which are personally chosen colleagues preferred by myself, to take possession of your records OR to deliver them to another LPC/LPC-Supervisor, LMFT/LMFT-Supervisor of your choosing.

EMERGENCY SITUATIONS

_____It is my desire to provide the highest level of care to clients both inside and outside of sessions. For scheduling and non-emergency situations, please contact me at 806.350.5861. In the event you encounter a personal emergency, which will require prompt attention, I will make every effort to accommodate an appointment. If your emergency arises after hours or on the weekend, clients are encouraged to contact a family member, call 911 or go directly to the nearest emergency department.

MODIFICATION AND CONFLICT RESOLUTION

_____It is agreed that any disputes or modification of agreement shall be negotiated directly between the therapist and client(s). If these negotiations are not satisfactory, then the therapist's client(s) agree to mediate any differences with a mutual acceptable third-party mediator, consisting first of another therapist of the practice. If these negotiations are unsatisfactory, the parties shall move to arbitration and then binding arbitration, choosing an arbitrator mutually agreeable by both. Litigation shall be considered only if and after all of these methods of resolution are given a good faith effort and are unsatisfactory.

CONFIDENTIALITY

Discussions between a therapist and a client are generally confidential and protected by law. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations:

- Child abuse
- Abuse of the elderly or disabled
- Abuse of patients in mental health facilities
- Sexual exploitation
- AIDS/HIV infection and possible transmission
- Criminal prosecutions
- Child custody cases
- Suits in which the mental health of a party is in issue
- Situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose
- Fee disputes between the therapist and the client
- Negligence suit brought by the client against the therapist
- Filing of a complaint with the licensing or certifying board

_____If you have any questions regarding confidentiality, you should bring them to my attention so that we can discuss this matter further. I hold confidentiality between clients in the highest regard and will make every effort to protect information shared in our session together. By signing this Information and Consent Form, you are giving consent to Virginia L. (Ginny) Monk to share confidential information with all persons mandated by law, with the agency or therapist that referred you and are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result. If you are (7n).

DUTY TO WARN/DUTY TO PROTECT

_____If my therapist believes that I (or my child, if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact my emergency contact in addition to any medical or law enforcement personnel deemed appropriate:

HEALTH DECLARATION: We are committed to providing the highest level of care for you and every other client of our practice. In light of the ever-evolving restrictions and requirements due to the COVID-19 outbreak, we are taking additional steps to ensure the well-being clients and staff. Out of an abundance of caution we are requiring all clients to make the following disclosures. Please initial statements and sign below.

_____ Neither I nor any family members have experienced flu-like symptoms in the past 3 weeks.

_____ In the event that either I or my family member have flu-like symptoms we will notify the therapist to reschedule the appointment.

_____ I understand that according to the CDC, people over the age of 65 and/or people of all ages with underlying medical condition are at higher risk should they contract COVID-19. If I self-identify as a member of the higher risk group, I understand and agree that I am aware of the risks of attending my therapy sessions, and my initials indicate that I accept those risks.

_____ I hold Virginia L. Monk, LPCS and the Counseling Offices of Amarillo Family Institute free, safe and harmless from any and all damages, liabilities, costs, losses, or expenses (including reasonable attorneys' fees and court costs arising out of or in connection with our attending therapy sessions, and any claim, demand, or action by a third party against Virginia L. Monk, LPCS and the Counseling Offices of Amarillo Family Institute in any way related to attending therapy sessions.

I ___ do /____do not give authorization for electronic transmissions concerning my appointments and/or therapy. This includes but is not limited to texting and email. Furthermore, I understand the inherent risks of these modes of communication and recognize that therapy is best served in the therapy room with as little outside communication as possible.

I **____do/____do not give authorization for therapists in training, interns, or students** to be present during my sessions to assist in facilitating training under the mission of the Counseling Offices at Amarillo Family Institute.

I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me and I understand that I may stop such treatment or services at any time.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I agree to participate in therapy with Virginia L. (Ginny) Monk, LPC-S.

_____ _____

Signature of Client Date

_____ _____

Signature of Therapist Date

The Counseling Offices at Amarillo Family Institute

4211 I-40 West Ste 101 Amarillo, TX 79106 (806) 350-5861

Federal Regulations

EFFECTIVE APRIL 14, 2003

Patient Consent Form to Release Information

The misuse of Personal Health Information (PHI) has been identified as a national problem causing clients and patients inconvenience, aggravation, and money. Although Amarillo Family Institute does not fall under the regulations and privacy rules of the Health Insurance Portability and Accountability Act (HIPAA) directly, the information we give to the management group that administers your insurance program may fall under the HIPAA requirements. Therefore, we want you to know that we strive to prevent improper disclosures of your PHI and make sure you are properly informed of your rights.

Our Policy Regarding Personal Health Information (PHI)

We want you to know that we respect the privacy of your personal medical and therapy records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to professionals, health care organizations and health insurance providers in order to secure proper treatment for you or payment of services provided to you.

Your Right to Your Records

We also want you to know that you have full access to your personal medical records. If you desire to see or have a copy of your records, you may make the request and we will make every effort to supply the review or copy within 72 hours.

Your Right to Refuse Release of Personal Health Information (PHI)

You may refuse to consent to the use or disclosure any or all parts of your Personal Health Information by not signing this form. Further, you may withdraw your previous consent to use or disclose your Personal Health Information at any time, but such a request must be made in writing. Please understand that if you withdraw previous consent, you cannot revoke actions that have already been taken which relied on your previous signed consent.

Our Right Regarding Refusal of Consent

If you refuse to consent to disclose your Personal Health Information (PHI), we will be unable to work with other health professionals, organizations, or insurance providers. Without your consent, therefore, we are forced to exercise our right to refuse treatment unless you plan to pay for services completely on your own.

I have read and understand the above information. Further, I give my consent to release my Personal Health Information for the purposes stated above.

Print Name: _____ Date: _____

Signature: _____

INTAKE FORM

Amarillo Marriage and Family Institute, Inc.
4211 I-40 West, Suite 101
Amarillo, Texas 79106

Phone: (806) 350-5861 www.amarillofamilyinstitute.com **Fax: (806) 358-4345**

PERSONAL INFORMATION

CLIENT(S) NAME: _____Maiden _____Date_____

PHYSICAL ADDRESS: _____
Street, City, State, Zip

PRIMARY PHONE: (_____) _____ CELL PHONE (_____) _____
Permission to leave message? YES NO
PRIMARY EMAIL: _____
Permission to Email and/or Text? YES NO

Birthdate: _____
Age: _____
Race/Ethnicity: _____
Birth State: _____
Relationship Status: _____

Last grade attended/degree completed: _____
Employer: _____
Length of Employment: _____
Occupation: _____
Annual Family Income: _____
(if requesting assistance with fees)

Emergency Contact: _____
Phone: _____
Address: _____
Relationship to the client: _____

PLEASE CIRCLE BELOW

Rate your physical health: Excellent Good Average Fair Poor

Recently: Lost Wt. Gained Wt. How much? _____

Average hours of sleep per night _____ Trouble with: falling asleep___ staying asleep____

Do you drink: coffee (____cups per day) tea (___cups per day) Cola (_____oz per day)

Please circle: Beer Wine Liquor Quantity per day_____ Quantity per week_____

Hours per day on computer for games, social media, etc.: _____ For work _____

Has anyone ever suggested there might be a problem with alcohol, computer, social media, shopping, or other excessive behavior? _____

Describe use of non-prescription drugs including aspirin _____
_____

Currently taking prescription drugs? (List type and reason for use)_____
_____

Family physician _____ What type of regular exercise? _____

Have you ever had a severe emotional upset? _____ If yes, describe: please use back if necessary: _____
_____

Did this upset require medication or hospitalization? ____ If yes, describe: _____
_____

Have you ever had thoughts of or attempted suicide? _____If yes, please explain:_____
_____

Are you currently seeing a therapist? Yes No Name _____Phone_____

Is spirituality important to you? ____not at all ___important _____very important

Do you have a spiritual orientation/where do you attend church? _____

FAMILY HISTORY

Raised by _____blood parents? _____other (explain)_____

Parents divorced? _____ If yes, how old were **you** at the time? _____

If parents are deceased, how old were **you** when they died? _____Father _____Mother

List brothers and sisters in birth order beginning with oldest (Include Yourself):

Name	Age	Sex	Marital Status	Residence Location
_____	____	____	_____	_____
_____	____	____	_____	_____
_____	____	____	_____	_____
_____	____	____	_____	_____

Marriage Information…If NEVER married, omit this section otherwise check all that apply:

_____presently married
_____remarried (____times/ dates: _____)
_____separated (_____months/years)
_____divorced (_____months/years)
_____widowed (_____months/years)

Spouse's name_____
Length of courtship: _____
Date of marriage: _____
Age when married-yours_____spouse_____
Spouse previously married? _____

How well do you and your spouse get along at the present time? Check One

____Very well ____Well ____OK ____Not very well ____Poor

List all of your children, whether they live with you or not, and any other persons presently living with you, such as your spouse's children, foster children, etc.

Name	Age	Sex	Live With?	Ours	Mine	Spouse's
_____	____	____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____

Does spouse have children from a previous marriage who live elsewhere? _____ if yes, with whom?
_____

State in a short phrase or sentence of current reasons for seeking therapy (presenting issue):

_____

_____

_____

When did the present problem start?_____

_____

Circle the severity of the concern in regards to the presenting issue:

MILDLY UPSETTING	MODERATELY SEVERE	VERY SEVERE	EXTREMELY SEVERE	COMPLETELY INCAPACITATING

Therapy/counseling before? YES NO If yes, how many sessions? _____

Currently seeing therapist/counselor? YES NO

Name of counselor, and dates of any previous counseling:_____

_____

How satisfactory was the therapy/counseling received (1 being not satisfied to 5 being satisfied)?

1	2	3	4	5

What else, if anything, has been attempted to correct the problem?_____

_____

Were you referred to us? _____ (If yes, by whom) _____

May we have permission to thank them for this referral? YES NO

In your estimation, circle how interested in counseling you are now:

SOMEWHAT	MODERATELY	VERY INTERESTED

Any other information important in preparation for counseling:_____

_____

What is the anticipated outcome of therapy? What is/are your goal(s)?_____

_____

Due to Coronavirus 19 concerns I agree to payment of services by this CC on file in my account.

Credit Card # _____Exp:_____V Code:_____Zip Code:_____

By signing below, you acknowledge you have read this notice and agree to the terms.

_____ _____

Signature of Client

_____ _____

Signature of Therapist **Date**