Virginia L. Monk, M.Ed., LPC-S

Licensed Professional Counselor/ Board Supervisor

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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. I am a Licensed Professional Counselor in the state of Texas under Occupations Code, Chapter 503, which allows me to provide individual, couples, family and group services. I am also a Licensed Professional Counselor Supervisor in the state of Texas and a National Certification Trainer in Treatment of Affairs for therapists. As a founder of *Restoration Therapy* many treatment plans are available to treat specific needs.

I work with individuals, couples, and families from across the lifespan dealing with various issues in their lives. I also facilitate Marital Intensive groups. I also have a B.S. in Mass Communications and Public Relations and provide group training initiatives (diversity training, leadership development, etc.) to a variety of schools, businesses and professional organizations. I facilitate Marital Intensive groups of 4 couples in 4 day Intensives and 2-3 day Private Intensives for marriages in distress at our Timbercreek Canyon Retreat.

Although I am well versed in hand ling a variety of client concerns, there may be situations that I will recommend you to another specialized therapist so that you will be better served. Please not 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 am unable to administer certain diagnostic tests.

SESSION INFORMATION AND FEES

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately SO 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 the office at 806-350.5861 at least 24 hours in advance. **Appointments that are not cancelled at least 24 hours in advance will be charged to your account.**

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. My fee for an initial session is $175.00. My fee for regular 50 minute sessions thereafter is $140.00. I do not charge for time spent on case notes or appointment preparation but telephone consults or reports are billed @$37.50 at 15 minute increments, my fee per person for group therapy is $50.00 per 90 minute session. Marital or family sessions can also be booked in two segments at the rate of $175.00 per hour.

In unusual cases, you may become involved in litigation that may require my participation. You will be expected to pay for the professional time required for my participation at the· rate of $800 per half day or $1600.00 per full day. My fee for outside group consultation, based on 90 minute sessions, is $250.00 per session, which includes travel time.

FEE SCHEDULE:

Initial Evaluation Session (1st visit)	$175.00
Regular 50 minute Office Visit (Couples 2 hour sessions may be preferred)	$140.00
Group Sessions (90 minutes)	$ 50.00
Court Appearances (Randall/ Potter -in advance)	1/2 day $800 /full day $1600.00

Payment of fees is expected at the time services are rendered. It is best to pay with cash or a check at the beginning of each session. Checks can be made out to Virginia L. Monk, LPC-S. I also accept Visa or MasterCard. We utilize the Square to process credit cards. You may also leave your number on file.

PAYMENT/ INSURANCE FILING: In some cases, treatment will qualify you for insurance payment. If you wish to file with your health insurance for therapy costs, I am considered out of network with most insurance companies. **Full payment is required until insurance information can be established.** Most insurance companies require that I provide a mental health diagnosis to a client before they will consider payment and then require consultation to approve sessions. **Relationship issues such as parent/ child or marital counseling usually do not qualify for insurance payments**.

Payment of fees, including any required co-pays that are established, is expected at the time of each appointment in full. I request that payment be made before the session begins. If you are using insurance benefits, my billing services will file insurance claims for you. Any insurance claims filed by this office are handled by Pamela Counterman in my office. By signing this agreement you are agreeing to pay for any services rendered which are not paid by you r insurance company.

RISKS AND 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, 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 you r personal goals for counseling.

EMERGENCIES: From time to time, you may encounter a personal emergency which will require prompt and immediate attention. Although I try to make myself available to you, there may be times where you cannot reach me. If you are in a crisis every effort will be made to return your call & schedule an appointment if necessary. However, please understand that your therapist may be in sessions and unable to return your call until later in the business day. Should you need immediate assistance or experience a crisis after hours or on the weekend, please call the Access Line at 1-800-537-2585 or go directly to Northwest Texas Hospital Emergency room. I f you feel that you may need a therapist on call for you at all times, please let me know and I will refer you to another therapist.

PROFESSIONAL RECORDS: Both law and the standards of my profession require that I keep appropriate treatment records. You are entitled to receive a copy of the records, or I can prepare an appropriate summary. Because these are professional records, they can be misinterpreted and/ or upsetting. If you wish to see your records, I recommend that you review them in my presence so that we can discuss what they contain. These records are confidential with some exceptions as noted within the confidentiality statement on the next page and as stated in the Notice of HIPPA Privacy Practices provided to you.

MINORS: If you are under eighteen years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is my policy to request an agreement from parents that they consent to give up access to your records. If they agree, I will provide them only with general information on how your treatment is proceeding unless I feel that there is a high risk that you will seriously harm yourself or another, in which case I will notify them of my concern. After termination of treatment and upon request, I will provide them with a summary of your treatment.

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.

Please be advised that the family and/ or marriage unit is considered to be my client. All parties must agree to release of any information. Although treatment may occasionally call for seeing a smaller unit of the whole Virginia L. Monk reserves the right to determine how to most effectively serve the whole.

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. Monk to share confidential information with all persons mandated by law, with the agency that referred you and the insurance ca1Tier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/ DUTY TO PROTECT: If my Therapist believes that I am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the 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 the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name _____ Telephone Number _____

_____

CONSENT TO TREATMENT : By signing this Client Information and Consent Form as the Client or Guardian of said Client, 1acknowledge 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. Monk, M.Ed., LPC-S. I authorize Virginia L. Monk's billing services to file insurance on my behalf, if applicable, and assign payments directly to Virginia L. Monk, LPC-S. I understand that if my insurance does not pay for my sessions, I am responsible for the payment of those services.

I (please circle one) **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 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.

_____ _____

Signature-Client Date

_____ _____

Therapist Date

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:_____

Virginia L. Monk, M.Ed. LPC-S

Texas Board Approved Supervisor
4211 1-40 W Suite 101 Amarillo, TX
79106

NAME_____Maiden_____DATE _____AGE_____
ADDRESS _____CITY _____STATE___ ZIP_____
HOME PHONE _____WORK PHONE_____ CELL PHONE _____
Do we have permission to leave messages? Yes No
Drivers Lic _____ST__DOB _____
Place of employment _____Job Title_____
Last grade attended or degree completed _____Annual Income _____
Marital Status_____ Notify in an emergency_____Phone_____
Person responsible for this account _____Relationship to client._____
Address _____ Home Phone_____
Permission for Email and/or Text? Yes No (Please Circle one or both)

PLEASE CIRCLE BELOW:
Rate your physical health: Excellent Good Average Fair Poor
Recently: Lost Wt. Gained Wt. How much? Ht._____Weight _____

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)
alcohol (___type _____ quantity per day/week)
Hours per day on computer for games, social media, etc: _____
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:_____
_____

Did this upset require medication or hospitalization? ____If yes, describe:_____
_____
Is spirituality important to you? not at all _important very important

If important, name of church/temple you attend: _____

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

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

May we have permission to thank them for this referral? Yes No

What are the concerns that prompted you r visit with me today?

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?	Our	Mine	Spouse's

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

Is there anything else you would like me to know prior to this appointment?

APPOINTMENTS MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE IN ORDER TO AVOID FULL CHARGES. I AM AWARE THAT ALL CHARGES ARE DUE AND PAYABLE AT THE END OF EACH SESSION AND BY MY SIGNATURE BELOW I UNDERSTAND THE APPOINTMENT CANCELLATION AND PAYMENT POLICY.

Signed:_____ Date:_____