Client Informed Consent

Jill Griffith, M.A., LPC-Associate
Supervised by Wib Newton, PhD., LPC-S, LMFT-S

Please initial next to each section indicating that the information has been read.

GENERAL INFORMATION _____ (initial)
My name is Jill Griffith, and I have a Master of Arts in Professional Counseling and am a Licensed Professional Counselor Associate #87702 by the State of Texas under the occupations code chapter 503 allowing me to provide individual, couples, family, and group services as a Licensed Professional Counselor Associate (LPC-Associate) under supervision. I currently work under the supervision of Wib Newton, PhD, LPC-S, LMFT-S.

I work with individuals, couples, and families from across the lifespan dealing with various issues in their lives. Although I can handle a variety of problems, there may be situations in which I will recommend you to another specialized therapist to be better served. Please note that I am not a psychiatrist (a medically trained doctor), therefore, I am unable to prescribe medication. I am also not a licensed psychologist and 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), Group, and Individuals with emphasis in Cognitive/Behavioral, Solution Focused, Emotion Focused, and Restoration Therapy Modalities.

APPOINTMENTS_____ (initial)
Your first initial visit will be an assessment session in which you and I will determine your concerns. If we both decide that I can provide your therapeutic needs, we will work on treatment objectives together. Appointments are typically scheduled on a weekly basis and are approximately 50 minutes. More frequent sessions or an intensive outpatient schedule are available if determined appropriate. Group sessions are approximately 90 minutes. Scheduling appointments is available by phone, email, or text. Any communication outside of business hours will receive a response on the following business day. If you must cancel or reschedule your appointment, please contact me at 806-350-5864 or 806-316-5059 **at least 24 hours in advance** of scheduled appointment. **Cancellations made less than 24 hours in advance of the scheduled appointment time will be charged the full session fee to your account.**

Due to the confidentiality policy, excluding minors, we are unable to schedule, confirm, adjust, or cancel any 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.

PAYMENT_____ (initial)
The session fee for an individual or couple is $75.00 and group sessions are $35.00 per person. Payments are accepted by check, cash, or square credit/debit card payments. I cannot accept insurance at this time. Full payment is expected at the beginning of each session. Subsequent sessions will then be scheduled at the conclusion of that session if determined necessary. By signing this agreement, you understand that you are fully responsible for all fees.

CONTACT OUTSIDE OF SESSIONS _____ (initial)
You may contact me outside of sessions by phone or email. Please limit that contact to scheduling issues. Issues related to therapy need to be discussed during session. Please know that any phone call lasting **more than 15 minutes** will be billed as a session.

EMERGENCY SITUATION _____(initial)
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 806-316-5059. 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.

CLIENT RECORDS_____(initial)
All our communications become part of the clinical record, including electronic communication. Adult client records are disposed of seven years after the file is closed. Guardians or conservators do have access to child-client files and will need to sign for consent of services (within joint custody cases, only one guardian or conservator is needed to sign for consent for the child). Minor client records are disposed of seven years after the client's 18th birthday. Should you request a copy of your counseling records, please be aware that a $30.00 record preparation fee will be incurred for files under 50 pages and a $50.00 record preparation fee will be incurred for files 50-100 pages. Additionally, a "Release of Records" form must be signed. An overall counseling summary, in lieu of records, will be provided free of charge upon request.

RELEASE OF INFORMATION _____(initial)
If information needs to be released it will only be done according to state law and with a written consent 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 and if mandated by the court.

LITIGATION_____ (initial)
In unusual cases you may become involved in litigation that may require my participation. At this time, all litigation requiring my participation will also require the participation of my supervisor, Wib Newton. At this the time notice is received of a scheduled court date, the following fees will become due for the professional time of your therapist. All fees are to be paid prior to the scheduled court appearance.

$300.00 (Jill Griffith) + $800.00 (Wib Newton) = $1100.00 for half day of professional time
$600.00 (Jill Griffith) + $1600.00 (Wib Newton) = $2200.00 for full day of professional time

In addition, there will be an invoice for travel and meal expenses, if incurred. In the event the court date is cancelled or rescheduled our office must receive notification 48 hours in advance. Please call 806-316-5059 or 806-374-5950. If the required notice is provided, the responsible party will receive a full refund of paid professional time. Failure to provide advance notice will result in your account being charged the full day of professional time as well as travel/meal expenses. By your signature(s) you acknowledge you have read this notice and agree to the terms and fully responsible for all fees.

MINORS _____(initial)
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) apart from extreme circumstances (see confidentiality above).

At the termination of treatment and upon request, your therapist will provide 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.

If the parents of the child receiving counseling are separated, divorced, or were never married, I need a copy of the divorce decree, custody decree, or other court orders affecting the rights of the parents, guardians, or others. I will need a copy of these papers before I can meet with your child. If I do not have the appropriate court orders, I will not be able to meet with your child for counseling.

CONFIDENTIALITY OF ALL ELECTRONIC COMMUNICATIONS _____(initial)
This includes but is not limited to the following: Email, Skype (or any other facetime 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 pragmatic and/or clinical concerns. 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.

Be sure to fully exit all online counseling sessions and emails. If you are unable to connect or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible call 806-374-5950 to schedule a new session time.

DUAL RELATIONSHIPS/SOCIAL NETWORKING _____(initial)
Not all dual relationships are unethical or avoidable. Dual relationship situations might impair your therapist's objectivity, clinical judgement, 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 (therapist) to others. Please be aware that your therapist will not accept friend/follow requests from any social media sites in the interest of protecting your privacy as well as maintaining professional boundaries.

INCAPACITY OR DEATH _____(initial)
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.

MODIFICATION AND CONFLICT RESOLUTION _____(initial)
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 these methods of resolution are given a good faith effort and are unsatisfactory.

RISKS/BENEFITS _____(initial)
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. Therapy is designed to assist clients in resolving issues and dealing with painful life problems. Your therapist will make every effort to make therapy successful in this manner; however, you should know that therapy is no guarantee that you will solve your problems and that issues will be resolved. Furthermore, please be aware that through the course of therapy, we may expose issues that may cause additional problems to you and bring more life distress. Participation in therapy means that you accept these risks and are willing to deal with the potential problems. 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.

CONFIDENTIALITY_____(initial)
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 in is 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:
  Complaints Management and Investigative Section
  P.O. Box 141369
  Austin, TX 78714-1369

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 Jill Griffith, M.A., LPC-Associate, supervised by Wib Newton, Ph.D., LPC-S, LMFT-S, to share confidential information with all persons mandated by law, with the agency that referred you and 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 _____(initial)
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 the following person(s) in addition to any medical or law enforcement personnel deemed appropriate.

Person to be Contacted	Phone Number	Relationship

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

Client Printed Name: _____

Client Signature: _____ Date: ___/____/____

APPLICABLE for MARRIAGE/COUPLE

Client Printed Name: _____ Client Printed Name: _____

Client Signature: _____ Client Signature: _____ Date: ____/____/____

APPLICABLE for MINOR

Client Printed Name: _____

Parent/Guardian Signature: _____ Date: ____/____/____

Signature of Therapist: _____ Date: ____/____/____

ASSOCIATE SUPERVISION AND RECORDED SESSIONS _____ (initial). As an LPC-Associate, I am supervised by Wib Newton, Ph.D., LPC-S, LMFT- S. I meet with my supervisor on a weekly basis as I continue to grow as a counselor. I may discuss some aspects of your counseling process with my supervisor and may ask to videotape your session to help the process. These recordings are used for educational purposes only, viewed only by the supervisor and are deleted immediately after viewing. You have the option to decline videotaping of your sessions, and that will have no effect on your therapy and/or my ability to see you. If you have any issues or concerns about my abilities as a counselor, please contact Wib Newton.

Wib Newton, PhD, LPC-S, LMFT-S
LPC-S License Number 14311
LMFT-S License Number 3794
Amarillo Family Institute
4211 I-40 West Suite 101
Amarillo, TX 79106
Phone: (806) 350-5862
Email: wibnewton@gmail.com

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

I (client) _____ (printed name) **DO/ DO NOT** consent to the videotaping of my sessions.

Client Signature: _____ Date: ___/____/____

If Minor:

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____ Date: ____/____/____

Minor Client Printed Name: _____

APPLICABLE for MARRIAGE/COUPLE

Client Printed Name: _____ Client Printed Name: _____

Client Signature: _____ Client Signature: _____ Date: ____/____/____

Therapist Signature: _____ Date: ____/____/____

Wib Newton, Ph.D., LPC-S, LMFT-S
Jill Griffith, M.A., LPC Associate
LPC-Associate Counseling Agreement

Please initial the following statements to acknowledge your understanding:

_____ I understand that I am seeing a counseling associate for counseling services.This associate is earning hours toward counseling licensure.

_____ I understand the limits of confidentiality as explained by my counselor and I have had the opportunity to ask questions about these limits.

_____ I understand that I may, at any time, request to see associate supervisor, Wib Newton, PhD., LPC-S, LMFT-S for counseling services.

_____ I understand that the dynamics of my case will be discussed for staffing and educational requirements with the counseling associate and supervisor.

_____ I understand that some sessions may be directly observed by the LPC Supervisor

_____ I understand that, with my permission, some sessions may be videotaped for supervision and educational purposes.

_____ I understand the supervisory relationship and the requirement for supervision do not otherwise affect my rights to confidentiality, which will be maintained within the limits of the law.

_____ I understand that I am not required to sign this document

HIPAA/HITECH

ACKNOWLEDGEMENT OF RECEIPT

Printed Client's Name: _____

Client's Date of Birth: ____/____/____

The office of Jill Griffith, M.A., LPC-Associate, supervised by Wib Newton, Ph.D., LPC-S, LMFT-S, is required by law to maintain the privacy of and provide individuals with the "Notice of Privacy Practices" with respect to your PHI/ePHI (Protected Health Information/Electronic Protected Health Information). This notice is located on our website and in paper format with our informed consent. You may also receive a paper copy at no charge upon your request. If you have any objections to this notice, please ask to speak with or leave a message at 806-375-5950 for my HIPAA/HITECH Certified Office Administrator.

I hereby acknowledge that I received and reviewed the HIPAA/HITECH Notice of Privacy Practice Document.

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

Client Printed Name: _____

Client Signature: _____ Date: ____/____/____

APPLICABLE for MARRIAGE/COUPLE

Client Printed Name: _____ Client Printed Name: _____

Client Signature: _____ Client Signature: _____ Date: ____/____/____

APPLICABLE for MINOR

Client Printed Name: _____

Parent/Guardian Signature: _____ Date: ____/____/____

Signature of Therapist: _____ Date: ____/____/____

INTAKE FORM
INFORMATION

PERSONAL INFORMATION

Client(s) name: _____

Legal guardian (if client is a minor): _____

Address: _____

Primary phone: _____ permission to leave message: yes no

Primary email: _____permission to email and/or text: yes no

Birthdate: _____

Age: _____ Race/ethnicity: _____

Relationship status: _____

Last grade attended/degree completed: _____

Occupation: _____ Employer/School_____ Length of employment: _____

Emergency Contact: _____ Phone: _____

Address: _____

Relationship to client: _____

MARRIAGE INFORMATION (if never married, omit this section**)**

Spouse's Name: _____

Length of courtship: _____ Date of marriage: _____ Age when married: _____ You _____Spouse

Previously Married: ____You ____ Spouse Length of Previous Marriage/s: _____ You _____ Spouse

Remarried: _____ You _____ Spouse # of Times Remarried _____ You _____ Spouse

Separated: ____ (____ mths/yrs) Divorced: ____ (____mths/yrs) Widowed: ____ (____mths/yrs)

Spouse's employer: _____ Spouse's occupation: _____

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

Name	Age	Sex	Live With?	Ours	Mine	Spouse's

Does your spouse have children from a previous marriage who live elsewhere? ____ If yes, with whom do they live? _____

PHYSICAL HEALTH

Rate your physical health: Excellent Good Average Fair Poor

Recently: Lost Weight Gained Weight How much? _____

Average hours of sleep per night _____ Trouble falling asleep? ____ Staying Asleep? ____

Caffeine intake: coffee_____ (cups/day) tea_____ (cups/day) Cola _____ (oz/day)

Alcohol intake: Beer Wine Liquor Quantity/day _____ Quantity/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, gambling, shopping, or other excessive behavior?
_____

Describe use of non-prescription drugs:
_____

Currently taking prescription medications. (List type and reason for use)
_____

Family Physician: _____

Exercise Frequency: _____ Type of Exercise: _____

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

_____

Did this upset require hospitalization? _____ If yes, please describe:
_____
_____

Have you ever had thoughts of or attempted suicide? _____ If yes, please describe:
_____
_____

Are you currently seeing a therapist? _____ If yes, 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: ___ Birth parents ___ Adopted Parents ___ Other (explain) _____

Parents Divorced? _____ If yes, what age were YOU at the time? _____

If parents are deceased, how old were YOU at the time of death? _____ Father _____ Mother

List siblings in birth order beginning with oldest: (include yourself)

GENERAL INFORMATION

Name	Age	Sex	Marital Status	Residence Location

Names of persons with whom the client is now living and their relationship to client:

NAME	AGE	RELATIONSHIP TO CLIENT

State current reasons for seeking therapy (presenting issue):

_____

_____

When did the present problem begin?

_____

_____

Circle the severity of the concern regarding the presenting issue:

Mildly Upsetting	**Moderately Severe**	**Very Severe**	**Extremely Severe**	**Completely Incapacitating**

Therapy/Counseling before: _____Yes _____No If yes, how many sessions? _____

Circle the type of therapy/counseling received:

Clinical Psychotherapy	**Pastoral Counseling**	**Enrichment Therapy**	**Other**

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

1	**2**	**3**	**4**	**5**

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

_____

_____

Describe your (client) relationship with your father:

_____

_____

Describe your (client) relationship with your mother:

_____

_____

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

SOMEWHAT	MODERATELY	VERY INTERESTED

Any other information in preparation for counseling:

_____

_____

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

_____

_____

Are you currently taking medication? _____ Yes _____ No If yes, please list names, dosages, and prescribing physician

_____

_____

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

Client Printed Name: _____

Client Signature: _____ Date: ____/____/____

APPLICABLE for MARRIAGE/COUPLE

Client Printed Name: _____ Client Printed Name: _____

Client Signature: _____Client Signature: _____ Date: ____/____/____

APPLICABLE for MINOR

Client Printed Name: _____

Parent/Guardian Signature: _____ Date: ____/____/____

Signature of Therapist: _____ Date: ____/____/____

Amarillo Family Institute
4211 I-40 West Suite 101
Amarillo, TX 79106
Phone: (806) 374-5950 Fax: (806) 358-4345

CREDIT CARD AUTHORIZATION FORM

EFFECTIVE DATE: _____/_____/_____

I, _____ authorize the office of __**Jill Griffith**_____ to place a charge on my credit/debit card for the purpose of Therapy.

The agreed amount of $_**75.00**____will be charged per session.

In the event of a NO SHOW or LATE CANCELLATION, a session fee of the ***AGREED AMOUNT*** will be charged to my card.

CC: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

EXP DATE: ____ / ____ CVV: ____ ____ ____ ____ (3 or 4 digits) ZIP: ____ ____ ____ ____ ____

_____ ____/____/____
Card Holder's Signature Date

_____ ____/____/____
Therapist or Office Staff Date

Please call your therapist if there are any questions of concerns regarding your account.