Treatment Agreement and Informed Consent

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

The benefits from counseling can include improved emotional functioning, reduction of symptoms, greater clarity, prudence, and confidence in decision making, and improved relationships. Counseling also has risks. Issues, feelings, and memories may emerge that are troubling; symptoms, in some cases, may increase. In relationships, one person may grow and improve while the other does not. Or people may move in different directions, with the result of a broken relationship. Benefits are more likely and risks are less likely when a person is open and cooperates with the therapy process.

The success of your therapy depends on your active participation, including attendance at sessions, investment in the work that we do together in session, and completion of between-session tasks. It will be up to you to decide what we talk about and to consent to the specific interventions recommended.

Education
I hold Master of Arts degrees in Counseling Psychology and Philosophy, and a doctorate in Theology. I am a fully licensed professional counselor in the State of Pennsylvania.

Confidentiality
As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. However, I may be required to breach confidentiality if:

- I believe that you present a clear and immanent threat to yourself or to the public.
- I believe that an identifiable potential victim is likely to be in danger.
- I believe that a child is being abused. In this case, the appropriate state agency will be notified, and I may be required to provide additional information.
- I am obliged by a court order, valid subpoena, or similar process to release your records or a summary of them.
- You file a complaint or lawsuit against me and I am required to disclose relevant information in order to defend myself.
- I become incapacitated or die. In that event, my supervisor will review my records and ensure that you receive continued care.
- Additionally, parents or legal guardians of non-emancipated minor clients have the right to access the client’s records.
Fee Schedule

Therapy sessions: $95.

Anger Management Classes:

- Individual sessions $45
  - 6 weeks $250; 8 weeks $300; 12 weeks $500  Payment due at the beginning of classes.

Other services, by arrangement.

OpenPath clients are entitled to a limited number of discounted sessions, to be negotiated.

Payment is due at the time of service in the form of cash, check or credit card. I also work on a sliding scale and reserve a limited number of sessions at a reduced rate. In the event you must cancel an appointment, please give me 24-hours' notice. If we are able to reschedule within the same week, no fee will be charged. Otherwise, you are responsible for the full amount, which may be charged to a credit card. The required information and signature will be kept on file for this purpose.

If you anticipate becoming involved in a litigation, please be advised that I may not consent to give testimony or produce documents in response to an attorney-issued subpoena. If your case requires my participation, you will be expected to pay for the professional time required at a rate of $500.00 base fee plus $100.00 per hour and federal mileage rate. Time spent preparing and writing summaries for court will be billed at $100.00 per hour.

Medical Issues

If you have any medical concerns that I should know about, please be certain to inform me of them.

Support in Crisis

I can be reached at the number and email at the top of this form. If I do not answer the phone, please leave a brief message, and I will return you call within 24 hours. If you choose to send an email, please be advised that email is not considered a confidential means of communication. If there is an emergency, please contact your physician or 911 for the police and ambulance.

Concluding Treatment

I believe that therapy should continue only until you have reached your goals or until it is no longer benefiting you. If I believe you have achieved your treatment goals or that you are no longer making progress or could benefit more in some other way, I will discuss this with you. If, at any time, you believe it would be best to discontinue treatment, you are free to do so, but please discuss this with me directly during a session together. Please also be aware that under unusual circumstances, including, but not limited to client threats or intimidation, failure to remit payment, or the violation of the terms of this agreement, I reserve the right to discontinue treatment at my discretion.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE TREATMENT AGREEMENT AND INFORMED CONSENT DOCUMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGMENT THAT YOU HAVE RECEIVED A COPY FOR YOURSELF.

________________________________________   _______________________
Client Signature                                      Date

________________________________________   _______________________
Signature of Spouse or Parent, if necessary    Date
# Intake Form

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
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<tbody>
<tr>
<td>Single □</td>
<td>Married □</td>
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<tr>
<td>Primarily Interested in:</td>
<td>How did you hear about me?</td>
</tr>
<tr>
<td>□ Individual Therapy</td>
<td>□ Psychology Today Listing</td>
</tr>
<tr>
<td>□ Couples Therapy</td>
<td>□ Pauljlachance.com Website</td>
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<tr>
<td>□ Family Therapy</td>
<td>□ Referred by:</td>
</tr>
</tbody>
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Street Address | City, State | Zip

Spouse/Partner: __________________________________________ □ Living Together □ Apart

Children:

_____________________________ Age__________________ □ Living Together □ Apart*

_____________________________ Age__________________ □ Living Together □ Apart*

_____________________________ Age__________________ □ Living Together □ Apart*

_____________________________ Age__________________ □ Living Together □ Apart*

*Child/Children’s address:

Contact information (Please indicate your preference by checking the box.)

□ Phone □ Email

If you give me permission to send emails, I may send information and updates related to my practice and handouts or weblinks which we discuss and that may be of interest to you in support of your treatment. I will not use email or text for treatment purposes other than pre-arranged reminders. Be aware that text and email may not be secure, and I cannot guarantee the privacy of the information you send to me or receive from me.
**In the past month or so have you experienced?**

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<tr>
<td>□ Extreme depressed mood</td>
<td>□ Mood swings</td>
<td>□ Rapid speech</td>
<td>□ Extreme anxiety</td>
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<td>□ Panic attacks</td>
<td>□ Phobias</td>
<td>□ Disturbed sleep</td>
<td>□ Hallucinations</td>
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<td>□ Memory lapse</td>
<td>□ Alcohol/substance abuse</td>
<td>□ Body complaints</td>
<td>□ Eating disorder</td>
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<tr>
<td>□ Repetitive thoughts</td>
<td>□ Anxiety</td>
<td>□ Time loss</td>
<td>□ Repetitive behaviors</td>
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<td>□ Homicidal thoughts</td>
<td>□ Chronic Pain</td>
<td>□ Trouble planning</td>
<td>□ Relationship trouble</td>
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<tr>
<td>□ Grief or Bereavement</td>
<td>□ Suicide thoughts or attempts</td>
<td>□ Other:</td>
<td>□ Other:</td>
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Please describe any major life changes in the past year (e.g. new job, new home, illness, relationship changes, etc.).

________________________________________________________________________
________________________________________________________________________

FAMILY MENTAL HEALTH HISTORY: In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.).

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<tbody>
<tr>
<td>□ Alcohol/Substance Abuse</td>
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<td>□ Anxiety</td>
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<td>□ Depression</td>
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<td>□ Domestic Violence</td>
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<td>□ Eating Disorders</td>
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<td>□ Obsessive Thoughts or Behavior</td>
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<td>□ Schizophrenia</td>
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<td>□ Suicide Attempts</td>
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<td>□ Other concerns (Please specify)</td>
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ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes
How would you describe your (dis)satisfaction with your current situation?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
How would you describe your faith or belief?
________________________________________________________________________
________________________________________________________________________

3. What do you consider to be some of your personal strengths and social supports?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. What do you consider to be some of your challenges or weaknesses?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________