

Professional Disclosure Statement

Nature of Counseling

Our approach to counseling focuses on how the influences of the past affect the decisions and interactions you are having today. Throughout your therapy we will work together to resolve internal conflicts, process through distressing thoughts and emotions, and analyze the impact of past and current relationships. In addition, both of us will work on counseling goals, which will govern the direction of your counseling process. Through directive techniques focusing on the here and now, we will work towards fostering your self-awareness, self-responsibility, and genuineness.

Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though we do ask that you participate in a termination session. You also have the right to refuse or negotiate modification of any of our suggestions that you believe might be harmful. At any time, either you or I may initiate discussion of possible positive or negative effects of entering/not entering counseling, continuing/terminating counseling, and using/not using certain techniques.

Psychodrama

Psychodrama is used as a way to sort through issues that are difficult to verbalize. Clients can use this to understand deeper issues, see patterns, and get motivation for a new plan. Specific tools may include scene setting, timeline, chair back, reversing roles, and group. Psychodrama is not for everyone, though many clients find this method to be fun and playful. It is your responsibility to inform your counselor if at any moment you are uncomfortable with the techniques being used and do not wish to continue.

Bioenergetic Analysis

Bioenergetic Analysis is a holistic form of psychotherapy that works with the physical, emotional, and mental patterns of the person to reduce emotional stress and help with the problems of living. It is a way of understanding personality in terms of the body and its energetic processes. In Bioenergetic Analysis, touch is sometimes used to help bring awareness to your body, to release the chronic tension held in muscle groups, to support you in the release of past traumatic material, and/or to assist you in making new movements outside your restricted range of motion.

The guidelines for using touch include asking your permission when touch is involved, respecting your personal boundaries and preferences in the use of touch, and staying within the guidelines for the use of touch designated by your therapist's licensing board and professional organization. Under no circumstances will the use of touch in therapy involve sexual areas of the body. Therapists trained in Bioenergetics Analysis have been certified to utilize the procedures described above. The purpose of the somatic interventions or movement experiences should be clearly explained by your therapist to your satisfaction, and at no time should your choice of whether to participate in the experiences be compromised.

Emotional Transformation Therapy (ETT)

ETT aims to transform emotional distress and somatic pain through the use of light, color wavelengths, and eye movements. ETT uses precise visual brain stimulation to target parts of the brain that are responsible for unwanted conditions. As in the case of seasonal affective disorder (SAD), research has shown that when light wavelengths are administered properly, they can improve an individual's emotional state. ETT may not be beneficial for people with a history of seizures or ocular conditions. Others may find the techniques in ETT to be overstimulating. It is your responsibility to inform your therapist of any physical or health conditions in the past before treatment.

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR is a comprehensive approach that uses dual stimulation to keep the information-processing system activated so learning can take place. Information received during traumatic events is often stored in implicit/motoric rather than explicit/narrative memory. Research conducted on the successful resolution of phantom limb pain and PTSD through EMDR suggests that information can actually be blocked off from the rest of the system and dysfunctionally stored. There is a long-lasting effect when information is not adaptively processed, and may intrude into a person's present experience. The goal of EMDR is to process these experiences and help liberate the client from their past so that they may fully engage in the present moment. The author of the theory stated, "A major criterion for the suitability of clients for EMDR is their ability to deal with high levels of disturbance potentially precipitated by the processing of dysfunctional information." It is also possible that high levels of disturbance are experienced between sessions as the information system continues processing. Eye movements should not be used if clients have a history of ocular conditions, or if the eye movements are painful or uncomfortable.

Professional Counseling

Sessions are usually held weekly for about 45 minutes. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to counseling sessions you arrange with me except in case of emergency when you may contact me by phone. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context or our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me in my professional role only. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you.

Referrals

If at any time, for any reason, you are dissatisfied with services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Texas State Board of Examiners of Professional Counselors (Mail code 1982, PO Box 14937, Austin, TX 78714-9347 or call 512-834-6658).

Should you and/or I believe that a referral is needed, I will provide some possible referral sources. A verbal exploration of alternatives to counseling will also be made available upon request.

Collaboration Consent

Bridging Harts is a Psychotherapy practice that offers a team approach. Our team meets regularly to discuss client issues as a way to support, supervise, and collaborate with one another and offer new perspectives for all client needs. Any sessions conducted by an LPC-Intern may be discussed with their LPC Supervisor.

Fees and Cancellation

In return for a fee of \$_____ (will be agreed upon) per session, I agree to provide counseling services for you. The fee for each session will be due and must be paid at the conclusion of each session. Cash or personal checks (made out to Katrena Hart) are acceptable forms of payment. If the fee represents a hardship to you, please let me know.

In the event that you will not be able to keep an appointment, please cancel at least **48** hours in advance. If proper notice is not received, you are responsible for payment for the missed session. A credit card is kept on file in case of missed appointments without **48** hours' notice.

Inclement Weather and Telephone Counseling

In the case of inclement weather, all counseling sessions will be held over the phone. If appointments are not cancelled at least **48** hours in advance, you are responsible for payment of the missed session. There may be times when you need to ask some questions, gain some reassurance, or get feedback. There will not be a charge for calls that happen once a month for a 15-minute time frame. For phone calls that exceed 15 minutes, or for times when you need telephone counseling support more than once a month, you will be charged at your hourly rate.

Returned Checks

Checks that do not clear at the bank will need to be reimbursed within **48** hours plus a **\$20.00** servicing fee. If your check does not clear on 3 or more occasions, you will be required to pay in cash.

Court Testimony

We as an agency are not interested in appearing in court for any reason. If we are subpoenaed to testify you will be expected to pay in advance a **\$5,000.00** retainer fee. In the event that we are required to testify there will be a fee of **\$225.00** per hour for each clinical hour spent preparing, as well as any driving time or waiting time.

If, at any time, you believe you are going to need to appear in court, we are happy to refer you to a new clinician who is willing and trained to support you in this way.

Emergency Sessions

There are times in which you may need a session during the weekend hours or on a day your clinician is not working. In the event that you need a session outside of your clinician's hours, you may request an emergency session with a **\$25.00** fee.

Written Documentation

There are times when you may need written documentation provided. In the event that you need a letter written, there will be a service charge of **\$30.00** for the clinician's time.

Records and Confidentiality

All of our communication becomes part of the clinical record, which is accessible to you on request. I will keep confidential anything you say to me, with the following exceptions;

- a. I determine that you are a danger to yourself and/or others;
- b. I am ordered by a court of law to disclose information;
- c. You disclose sexual contact with another health professional;
- d. You sign a release for me to tell someone else; or
- e. You disclose information regarding physical harm to a minor or elderly person

* Please note that Bridging Harts uses a second party for billing and filing purposes. Our staff team meets regularly to discuss case dynamics.

Communication and Confidentiality

In an attempt to help guide you during the age of computer technology, we want to keep you informed and keep your privacy as protected as possible.

Please initial below acknowledging that you are aware and informed:

_____ I understand that communication between staff members and clients is often done through, email, texting, newsletters, and social media. I understand that confidentiality cannot be guaranteed using these communication forums. Bridging Harts' staff will protect these sources with security codes and passwords appropriately.

_____ Texting or emailing personal, medical, or clinical information cannot be securely protected. If you text or email a question, you are giving permission to answer your question through this type of technology. Doing so, you are aware confidentiality may be compromised as the ability to protect all information via text or email is not possible. Bridging Harts' staff will protect these sources with security codes and passwords appropriately.

_____ If you join any social media forums through Bridging Harts and choose to post information, you have waived your rights regarding the confidentiality of your post because of the nature of social media.

_____ If you join a training group or therapy group the counselor/trainer is required to keep your information private, yet choices group members make in regards to confidentiality cannot be controlled by the therapist.

_____ You have the right to refuse dialogue and supervision between staff members (unless your counselor is under supervision). You have the right to refuse to share with others what is discussed between you and your clinician.

**BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND
AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.**

Client Name

Clinician Name

Client Signature

Clinician Signature

Date

Date

Credit/Debit Card Payment Consent Form

(A credit card is kept on file in case of missed appointments without **48** hours notice.)

Client Name _____
Print Last First Middle Initial

Name on Card if different _____

I authorize: *Bridging Harts Psychotherapy*
to charge my card for professional services for the amount of \$_____ per session.

I understand that missed appointments with less than 48 hours cancellation will be charged to my account.

Type of Card: VISA MasterCard Exp. Date _____

Card Number _____ - _____ - _____ - _____

CVV Number _____

Card Holder's Billing Zip Code _____

Client Signature

Date

Adult Intake

The requested information will become part of your file and is limited to the guidelines of confidentiality.

Name:

Address:

City	State	Zip
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Age _____ Date of Birth _____

Home Phone: _____

Work Phone: _____

Cell Phone _____

Email Address: _____

Employer: _____

Position: _____

How long have you been at your present job? _____

In case of emergency, please contact:

Name:

Address:

City	State	Zip
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Home Phone: _____

Work Phone: _____

Your relationship to this person: _____

Who referred you for Counseling Services? _____

What do you hope to gain from counseling? _____

OCCUPATION

Primary Occupation: _____ Duration: _____

Kinds of jobs held in the past: _____

What about your present job do you enjoy? _____

What about your present job do you not enjoy? _____

What are your work ambitions? _____

Have you ever been fired from a job? _____ If yes, please explain the circumstances:

Have you served military? _____ Branch _____ Dates: _____

EDUCATION

Years of school completed _____ Degrees conferred _____

Do you have any further education goals? _____ If so, what? _____

FAMILY OF ORIGIN

Father's Name _____ Living or Deceased _____

If Deceased, age you were when it happened and how you processed it: _____

His occupation _____

How would you describe your father? _____

What is his attitude toward you? _____

How would he describe you? _____

Do you have or did you have a step-father? _____ Ages? _____

Mother's Name _____ Living or deceased _____

If deceased, age you were when it happened and how you processed it: _____

Her Occupation _____

How would you describe your mother? _____

What is her attitude toward you? _____

How would she describe you? _____

Do you have or did you have a step-mother? _____ Ages? _____

Please list your siblings by names and ages, from oldest to youngest. Include yourself in the listing.

Name	Age

To whom do you feel closest in your family currently? _____

As a child, who gave you the greatest caring and support? _____

Have any significant family members died? _____ If so, indicate who and your age when they died? _____

Has anyone in your family suffered from alcoholism, mental disorders, severe depression, or anything that might be considered a serious illness? _____

RELATIONSHIPS

Are you currently involved in an intimate relationship with another person? _____

If so, please indicate nature (married, dating, etc.) and duration: _____

Partner's age _____ Partner's occupation: _____

Personality of your partner _____

In what ways is there compatibility? _____

In what ways is there incompatibility? _____

List your children by name, sex, and age: _____

Do any of your children present special problems? _____

Have you lost any children? _____

Do you have people in your life that you consider very close friends? _____

Please name these friends: _____

Do you have a support system you can turn to in times of need (i.e. church, Alanon, AA, etc)? _____ If so, name this system: _____

HEALTH

Physician: _____ Phone and Address: _____

List any significant health problems/Concerns: _____

List any current medications and what you take them for: _____

Please list other medications that you take with some frequency (including such things as aspirin, decongestants, birth control pills, valium, sleeping pills, diet pills, etc.)

Please list any surgeries you have had and the age you had it? _____

Please list any other hospitalizations, even visits to the emergency room, include reason and age: _____

Have you experienced any significant weight loss or gain? _____ If so, please indicate year(s) of these occurrences and the amount of change _____

Do you exercise regularly? _____ Type: _____

Do you smoke? _____ If so, how often and how much? _____

Do you drink alcohol? _____ If so, _____ Times per week, _____ drinks per time

Drink of choice _____ Do you binge drink? _____

Do you take drugs? _____ If so, describe your drug history, how often, age began, what types and age stopped as well as what you did to prevent it? _____

Have you ever had a problem with alcohol or drugs? _____

LEGAL

Have you ever been arrested? _____ If so, for what? _____

Have you ever been convicted of an offense other than a minor traffic violation? _____

If so, when and for what? _____

Have you experience any other legal problems? _____

PERSONAL

Please circle any of the following that apply to you:

Nightmares	Anxiety	Unable to relax	Sexual problems
Panic attacks	Dizziness	Feel insecure	Feel inferior
Headaches	Stomach trouble	Bowel problems	Often Angry
Suicidal ideas	Insomnia	Depression	Impulsiveness
Can't cry	Cry often	Bulimia	Anorexia
Stealing	Lying	Being Dramatic	Debt
Paranoia	Grief	Obsessions	Worrying
Molestation	Incest	Rape	Violence

List your 5 main fears: _____

Present interests, hobbies, activities: _____

What are the goals in your life? _____

Briefly describe your religious beliefs: _____

Are there problems with your sex life? _____ If so, what? _____

Have you had sexual problems before? _____ If so, what? _____

Do you feel you have some unusual or uncommon sexual practices? _____

Have you ever felt suicidal? Yes No If yes, when did you last feel suicidal?

Have you sought counseling before? Yes No If yes, please indicate, name of therapist,
what years or months in therapy, and what issues processed? _____

Has anyone close to you died? _____ If so, who and how old you were at the time:

Have you experienced other losses in your life (i.e., divorces, bankruptcy, child who is alienated
from you, etc.) _____

Do you have any resentment? _____ if so, list: _____

What was the best period of your life and why? _____

What was the worst period of your life and why? _____

What do you worry about most? _____

After you die, how would you like to be remembered? _____

Please rate your degree of satisfaction in the following areas of your life:

	Unsatisfied					Satisfied	
Job	1	2	3	4	5	6	7
Primary Relationship	1	2	3	4	5	6	7
Child Raising	1	2	3	4	5	6	7
Financial Decisions	1	2	3	4	5	6	7
Sexual Relationship	1	2	3	4	5	6	7
Educational	1	2	3	4	5	6	7
Health	1	2	3	4	5	6	7
Spiritual	1	2	3	4	5	6	7
Friends	1	2	3	4	5	6	7
Self-esteem	1	2	3	4	5	6	7
Other_____	1	2	3	4	5	6	7

Is there anything else I need to know but have not asked?

How are you likely to sabotage your therapy? _____
