Informed Consent Policies and Procedures

Welcome to Donna Shin Therapy and Wellness. Donna Shin, LCPC has received a Master of Science degree in Pastoral Counseling. Please ask your therapist any questions and feel free to discuss any concerns regarding this consent form.

CONFIDENTIALITY

We maintain a policy of strict confidentiality in all matters pertaining to our clients. At times your therapist may discuss aspects of your therapy with a supervisor. As issues are presented, the therapist will protect the client's confidentiality by using only the client's first name and remove any identifying characteristics.

Donna Shin, will not disclose any information about you except under the following circumstances:

1. You threaten to harm yourself or someone else.
2. You are involved in legal action and the court has ordered your records.
3. You or your child states being abused as a minor, and this abuse has not been reported previously.*
4. Your child is under 18 years of age and is at risk of being abused.*
5. The abuse of a vulnerable adult is disclosed.

* Child abuse is sexual or physical abuse, neglect, or mental injury by a family member or household member, a caretaker, or a person who has permanent or temporary custody. Maryland state law mandates discloser in such cases.

INFORMED CONSENT

In all likelihood, you are seeking counseling because of some difficulty or crossroads in your life that you wish to address. Your therapist is here to assist you in that process. While being in therapy can be very helpful, it is not without possible risk. Those risks may include but are not limited to:

- You may feel worse before you feel better.
- You will have to "work" for therapy to be helpful to you.
- You may experience mood changes that could affect your day to day functioning.
- You may experience some mild or severe depression that could result in a referral to a physician/psychiatrist for medication evaluation.
- As you learn new ways to address troubling situations, the people around you may change their behavior and complain that you have changed.
- You may decide to make changes in your life.

CLIENT THERAPIST RELATIONSHIP

We encourage you to let your therapist know how you think you are doing in therapy, what you find helpful and not, and what areas you would like to stress in treatment. In turn, your therapist will provide you regular feedback of her impressions of your progress or areas of concern.

This information is required by the Board of Professional Counselors and Therapists which regulates all certified and licensed counselors and therapists. Maryland Department of Mental Health and Hygiene, Board of Professional Counselors and Therapists, 42011 Patterson Ave. Baltimore, MD 21215 410-764-47

TERMINATION OF SERVICES

The therapist reserves the right to terminate therapy at her discretion. Reasons for termination include; untimely payment of fees, failure to comply with treatment recommendations, conflict of interest, failure to participate in therapy, the client's needs are outside the scope of competence or practice, or the client is not making adequate progress in therapy. The client also has the right to terminate therapy at her/his discretion.

If you fail to keep your standing appointment for two consecutive weeks without calling to cancel or reschedule, we will assume that you no longer wish to receive services and will send you a notice of termination.

APPOINTMENTS AND CANCELLATIONS

Therapy works best when both appear for scheduled appointments. The agreement we make each time we schedule an appointment is to honor each other's commitment of time and effort by being there. To ensure fairness to all, please be on time for appointments. If you are late, please be advised that your session will last only for the remainder of your scheduled session. If you need to cancel your appointment in the event of an emergency, please leave a message for your therapist on her voice mail. We ask that cancellations be made 24 hours in advance. Appointments missed or those cancelled with less that 24 hours notice will be charged as usual.

RETURNED CALLS OR E-MAILS

Phone calls will be returned within the business day, and e-mails will be returned within 2 business days of the receipt of the message. All emergencies should be directed to call 911 or to go directly to the hospital emergency room for immediate treatment.

In the event of the therapist's demise, all records will be released to a representative of the therapist's practice estate and in specific instances, a law enforcement official.

I confirm that I have read and understood the policies of Donna Shin Therapy and Wellness.

_____ _____

Client's signature Date

_____ _____

Therapist's signature Date

Client Information

Starting date: _____ Client#_____ Closing date:_____

Primary Counselor:_____

Full Name: _____ _____ _____

First Middle Last

If client is a minor, please provide information:

Mother's Name: _____ Father's Name: _____

Signature of parental consent to treat a minor :_____

Client's Birth date: _____Age: _____ Gender: ☐ Male ☐ Female

Street Address: _____

_____

Home Phone: _____ Discretion Advised ☐ YES ☐ NO

Cell Phone: _____ , OK to text___, Work Phone:_____Email:_____

Where do you prefer us to contact you? _____ Emergency contact_____

Ethnic Background: ___ African American ___ Asian/ Pacific Islander ___Caucasian/White

___ Hispanic/ Latino(a) ___ Native American ___ Other

Physical Disability: ☐ No ☐ Yes Describe: _____

Mental Disability: ☐ No ☐ Yes Describe: _____

Health:

Last Doctor's visit: _____ Physician's name:_____ Phone _____
Date

Medications:_____

_____

Reasons:_____

Briefly describe health, problems, and any hospitalizations_____

Are you currently under a psychiatric care, alcohol, or drug treatment? If yes, give name of doctor and brief explanation_____

Describe if any, current and/or past use of alcohol, caffeine and/or smoking

_____

Describe any past counseling_____

Household Status: Marital Status: ___ Married ___ Single __ Separated ___ Divorced

___ Widowed ___ Engaged

Are you currently living with your partner? ___ Yes ___ No **Partner's Name**_____

Please provide a brief description of your spouse/partner (supportive, angry, controlling…)

_____

Is your partner employed? ___ Yes ___ No Disabled___ Yes ___ No

Do you have any children? ___ Yes ___ No Living with you? ___ Yes ___ No

Names/Ages of children:_____

Please list your father, mother, sisters, brothers, stepfamily relations or any family members who have had a significant effect on your life (either positive or negative)

Name	Sex	Age or yr. of death	Relationship to you	Describe him/her

Background Information

Education: ___ No schooling ___ Student ___ No High School __ Some H.S __ H.S. Grad Vocational Training ___ College (0-3) ___ College Degree ___ Advanced Degree

Current Occupation:_____

Estimate Annual Household Income: ___ 0- 10,000 ___ 10,000- 25,000 ___ 25,000-50,000

__50,000- 70,000 ___70,000- 90,000 ___100,000-125,000___130,000-150,000 ___200,000+

Source of Income: ____ Wages/Salary ___ Alimony ___ Child Support ___ Retirement

___ Social Security ___ Unemployment ___ Other _____

Employment: ___ Never employed ___ Unemployed ___ Disabled

_____ Full-time _____ Part-time _____Retired _____ Social Security

Seeking Christian / Spiritual / Counseling _____Yes _____No

Presenting Issues and Goals: Please describe why you are coming to therapy. (problems, symptoms, how long..., use back if necessary.

_____

_____

I _____ do sign that the information given today is true and accurate information.

_____ _____

Client's signature Therapist's signature

_____ _____

PRINT NAME Date

HIPAA Consent Form

I give this practice and Donna Shin, LCPC my consent to use or disclose my health information to carry out my treatment, to obtain payment from insurance, and for health care operations such as billing, statements or quality reviews.

I have been informed that I may review Donna Shin Therapy and Wellness's confidentiality agreement prior to signing this contract.

I understand that Donna Shin Therapy and Wellness has the right to change or update their confidentiality agreement and that I may obtain any revised notices from Donna Shin, LCPC.

I understand that I have the right to request a restriction on how my protected health information is used. However, I also understand that in extenuating circumstances Donna Shin, LCPC is not required to agree to this request.

I understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

_____ _____

Signature of client, parent or legal representative Date

If signed by client representative, state relationship to client_____

_____