Tensegrity
COUNSELING ASSOCIATES

Terri Slack, LPC, LADC
1733 W 33rd St., Suite 120, Edmond, OK 73013
Phone: (405) 285-7332 Fax: (405) 285-7338

CONSENT FOR TREATMENT & POLICIES

Welcome! I am honored that you chose me to provide your individual, couples, or family therapy services. My mission is to provide you with quality care that fits your needs. It is my belief that every person is unique and deserves a customized treatment plan. I am willing to incorporate the therapy techniques that meet your specific needs. I am also committed to adhering to guidelines that protect you as my client. As a result, I would like for you to be aware of the following guidelines before your mental health and/or addiction treatment with me begins.

Confidentiality:
Your verbal communication and clinical records are strictly confidential except for:
a) Information (diagnosis and dates of service) shared with your insurance company to process your claims;
b) Information you and/or your child(ren) report about physical or sexual abuse; then, by Oklahoma state law, I am obligated to report this to the Department of Human Services;
c) Where you sign a release of information to have specific information shared;
d) If you provide information that informs me that you are in danger of harming yourself or others;
(e) Information necessary for case supervision or consultation;
(f) When required by law.

A transfer plan is in place in the unlikely event that I am unable to provide ongoing services. Your records will be maintained by the backup therapist for a period of 7 years.

CLIENT INITIALS: _____

Emergency Services:
Tensegrity Counseling Associates is not an emergency service. If an emergency for which the client or their guardian feels immediate attention is necessary and I am unable to return your call within a reasonable amount of time, the client or guardian understands that they are to contact 911, go to the nearest emergency room for those services, contact the Crisis Center at (405) 522-8100, or call the Suicide Prevention Hotline at 1-800-784-2433.

CLIENT INITIALS: _____

Financial & Insurance Issues:
As a courtesy, I will bill your third-party payer, responsible party or insurance company. If a third-party is paying for your services, you will need to sign a release giving me permission to discuss financial matters relating to your treatment services with the third-party. Additionally, the third-party will need to make financial arrangements directly with the office manager. **Payment in full is required at each session**.

CLIENT INITIALS: _____

Canceling or Rescheduling Appointments:

Your time is extremely valuable. Every effort is made to ensure that your session is productive and uninterrupted. If you are unable to keep your appointment, please give a 24-hour notice of cancelation so that you will not be assessed the **$125 fee**. Often there are others that would like to fill your session time in the event you cannot keep your appointment. I appreciate your cooperation in trying to provide high quality service.

CLIENT INITIALS: _____

Involvement in Legal Matters:

My services **do not** include court related work, testifying, depositions, child custody disputes, reports or letters written to the judge, or discussing matters with your attorney. If I am forced to provide such services my court fees will apply (please see the fees page) and you will be required to pay in advance.

CLIENT INITIALS: _____

Professional Consultation:

As a therapist, it is helpful to consult with a professional colleague regarding treatment issues that arise with my clients. All mental health professionals are bound by confidentiality laws as well as a code of ethics. If you have an issue with this please speak to me about it so that we can discuss it together.

CLIENT INITIALS: _____

Couples & Family Counseling:

Working with couples and families is different than individual therapy. All members of the session are considered "the client" together as a unit and are entitled to rights of informed consent and confidentiality. This means that all persons with legal status would have to sign a release of information before any information could be released outside of the system. I may on occasion meet with people individually as needed for supportive purposes for the greater good of the family or couple unit, but I adhere to a strict "no secrets policy". While it is not my practice to reveal information from individual sessions, I also cannot guarantee complete confidentiality as the issues overlap. If you are concerned about details that need to be kept secret, then it will be important for you to have your own individual therapist separate from my services.

CLIENT INITIALS: _____

No Secrets Policy (This applies to couples therapy only):

I view the client, couple, and/or family as a unit of treatment. Therefore, it is my practice to adhere to a "no secrets" policy in our work together. This means that I may choose not to partake in keeping secrets from members of the therapeutic system. If you are participating in couple's or family therapy, any information you disclose to your therapist may be openly discussed with other participating parties as part of treatment. Therefore, if you have secrets to keep from the other members of the therapy process you will need to do so in an individual therapy setting with a separate therapist. If you need assistance finding an individual therapist please let me know and I will give you some referrals.

CLIENT INITIALS: _____

Progress During Treatment:

Making progress and meeting your treatment goals are important. If at any point, you do not feel like you are making the progress you want or you feel like we are not a good match for each other please let me know. I want you to feel like you are getting what you need out of our time together. I will not take it personally if you feel like you need to work with another therapist, want to change the direction of treatment, or want to change your treatment goals. I am open to discussing these things at any time. If you need help finding a therapist more compatible with your needs I would be happy to provide you with contact information of other therapists I know.

CLIENT INITIALS: _____

If you have questions regarding your care, please let me know. Any non-emergency phone messages will be returned as scheduling allows, but primarily will be returned at the end of the day.

I have read and understand the **Consent for Treatment. By signing below, I certify that I agree to these guidelines as defined above.

Signature: _____ Date: _____

Printed Name: _____

I also certify that I have received a copy of the **Notice of Privacy Practices detailing the provisions of HIPAA and my privacy rights.

Signature: _____ Date: _____

Printed Name: _____

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

Decision to Meet Face-to-Face

If you choose to meet in person for some or all future sessions, please keep in mind that if there is a resurgence of the pandemic or if other health concerns arise, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law. If your insurance does not cover telehealth you will be responsible for the full cost of the session.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the potential risk of exposure to the coronavirus (or other public health risk).

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. ___
- You will wait in your car or outside until no earlier than 5-10 minutes before our appointment time. I will come to the door and let you in at the appointment time. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- If you want me to wear a mask in our therapy sessions you will let me know. ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. ___
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- You will take steps between appointments to minimize your exposure to COVID. ___
- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know. ___

- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth. ___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Client Signature Date

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SOCIAL MEDIA POLICY

Email
Please use email to contact me for administrative reasons only (modifying appointments, billing information, etc.). Please do not email content related to our counseling sessions, unless otherwise discussed. Email communication is not completely secure or confidential. Any emails I receive from you and any responses I send to you become a part of your legal record.

Text Messages
Please do not send text messages, unless otherwise agreed upon. I will not respond to texting. Any text message I receive from you becomes a part of your legal record.

Friending
I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends on these sites can compromise your confidentiality and our therapeutic relationship.

Following
I will not follow any client on Twitter, Instagram, blogs, or other apps/websites. If there is content you wish to share from your online life, please bring it into our sessions where we can explore it together.

I have read and understand the **Social Media Policy. By signing below, I certify that I agree to these guidelines as defined above.

Signature: _____ Date: _____

Printed Name: _____

STATEMENT OF PROFESSIONAL DISCLOSURE

This document is to inform you about my professional training, orientation/techniques, experience, fees, and credentials. I am a Licensed Professional Counselor (LPC) by the Oklahoma State Department of Health, license number 4164, and a Licensed Alcohol and Drug Counselor (LADC) by the Oklahoma Board of Licensed Drug and Alcohol Counselors, license number 638.

The licensing website is listed below where you can access the law and regulations which govern my license. I will furnish you with printed materials about the requirements of my licensure if you so desire. You may contact, without giving your name, the licensing boards at:

State Board of Behavioral Health Licensure
3815 N. Santa Fe,Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
Website: www.ok.gov/behavioralhealth

Oklahoma Board of Licensed Drug and Alcohol Counselors
101 NE 51st Street (physical address)
Oklahoma City, OK 73105
P.O. Box 54388 (mailing address)
Oklahoma City, OK 73154
Telephone: (405) 521-0779
Fax: (405) 521-0291
Website: www.okdrugcounselors.org

Terri Slack, M.A., LPC, LADC has satisfactorily supplied me with information regarding her practice, licensure, and professional development.

_____ _____
Signature of Patient/Parent/Guardian *Date*

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FEES FOR SERVICES

Individual Therapy per hour	$160
Missed Appointment/No Show/Late Cancelation fee	$125
Returned checks	$30

Telephone discussions longer than 5 minutes and the preparation of reports will be charged according to my hourly rate prorated according to the amount of time spent.

Court Fees:

The following fees will be assessed to you, the client or client's guardian, if I must appear in court for any reason, under any and all circumstances, relating to the client or client's family.

➢ Travel time per 15 miles	$120
➢ Court appearance *(minimum of 4 hours including commute & waiting)	$1280
➢ Each additional hour for court appearance	$320
➢ Preparation of reports for court (per 15 minutes)	$120
➢ Emergency appearance (less than 14 days' notice)	$500/hr.

***Appearance must be scheduled at least 14 days in advance. Court fee is due at the time of scheduling the appearance and is non-refundable without a 7-day notice for cancellation. These fees are subject to change without notice.**

I hereby acknowledge that these services are not a benefit of my health coverage and I will be personally responsible for the payment in full of the billed charges for these services.

Signature: _____ Date: _____

Printed Name: _____

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APPOINTMENT REMINDERS

As a courtesy, we offer automated appointment reminders. Please indicate below how you would like to receive reminders. Please just choose one.

Your name: _____

☐ Via a text message on my cell phone (normal text message rates will apply)

Cell # _____

☐ Via an email message to the address listed here

Email address _____

☐ Via an automated telephone message to my home phone

Home # _____

☐ None of the above. I'll remember my appointments on my own. **(Missed appointment fees will still apply)**

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Signature: _____ Date: _____

Printed Name: _____

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Client Information Form

Name: _____ Age: _____ Date: _____

Street Address: _____ Suite/Apt. #: _____

City: _____ State: ____ Zip Code: _____

May we send mail here? ☐ Yes ☐ No

Date of Birth: _____ Sex: ☐ Male ☐ Female

Parent/Guardian: _____ Relationship: _____

How did you find out about my services? ☐ Psychology Today ☐ Facebook

☐LinkedIn ☐ Webpage ☐ Person: _____

Contact Information:

Home #: _____OK to leave message? ☐Yes ☐No

Work #: _____ OK to leave message? ☐Yes ☐No

Cell #: _____ OK to leave message? ☐Yes ☐No

Email: _____ OK to email you? ☐Yes ☐No

Emergency Contact:

Name: _____ Relationship to you: _____

Address: _____

Phone #: _____

Insurance Information:

Primary Insurance: _____ Member ID#:_____

Policy Holder Name: _____Policy Holder Birthdate: _____

Is there anyone you want to grant permission to discuss with the therapist information relating to your treatment plan? If so, please list their name and relationship to you.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Work/School Information:

Status: ☐ Full-time student ☐ Part-time student ☐ Full-time work ☐ Part-time work

If student, where do you attend school?

_____

Students, what are you majoring in?

_____

Occupation: _____ Employer: _____
How long? _____

Ave. Hours Worked Per Wk.: _____ Education level completed? _____

Have you ever served in the military? ____ If yes, how long? _____

Demographic Information:

Ethnic/Racial background: _____

Sexual Orientation: _____

Religious/Spiritual background: _____

Involvement in religious/spiritual activities: ☐ none ☐ some/irregular ☐ active

Relational Information:

Current Relationship Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

If in relationship, how long? _____

If separated, divorced, or widowed, how long? _____

Number of previous marriages for you? _____ Your partner? _____

Partner's Name: _____ Partner's Age: _____

Partner's Occupation: _____

Ave. Hours Worked Per Wk.: _____

Does your partner support you seeking counseling? ☐ Yes ☐ No ☐ Partner doesn't know

With whom do you currently live? Please list their names, ages, and relationship to you.

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Health Background:

List all current medications and dosages, including supplements:

Name	Dose	How often	Reason	Date Started	Prescribing Dr.

Are you taking these medications according to your doctor's recommendations?

☐ Yes ☐ No

List all hospitalizations, severe injuries, head injuries that involved loss of consciousness, and current as well as past health problems:

Health Problem/Injury/Operation	Date	Currently a problem?

List any allergies you have: _____

Approximate date of your most recent physical examination: _____

Women: # Pregnancies _____ # Births _____ # Abortions _____ # Miscarriages ____

List any addiction/substance abuse treatment or psychiatric treatment and dates:

Name of Treatment or Psychiatric Facility	Dates	Inpatient/Outpatient

Please indicate if you have ever experienced any of the following:

Historical Information	Yes	No
Have you ever been in legal trouble?		
Is there a history of mental health problems, suicides, or suicide attempts in your family?		
Have you ever attempted suicide?		
Do you currently use alcohol?		
Do you currently use street drugs?		
Do you currently use medicines that are not prescribed to you by a doctor?		
Do you currently use tobacco/nicotine?		
Did a parent or other adult in the household **often or very often**…Swear at you, insult you, put you down, or humiliate you? **or** Act in a way that made you afraid that you might be physically hurt?		
Did a parent or other adult in the household **often or very often**…Push, grab, slap, or throw something at you? **or** Ever hit you so hard that you had marks or were injured?		
Did an adult or person at least five years older than you **ever**…Touch or fondle you or have you touch their body in a sexual way? **or** Attempt or actually have oral, anal, or vaginal intercourse with you?		
Did you **often or very often** feel that…No one in your family loved you or thought you were important or special? **or** Your family didn't look out for each other, feel close to each other, or support each other?		
Did you **often or very often** feel that…You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
Were your parents **ever** separated or divorced?		
Was your mother or stepmother: O**ften or very often** pushed, grabbed, slapped, or had something thrown at her? **or Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard? **or Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?		
Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
Was a household member depressed or mentally ill, or did a household member attempt suicide?		
Did a household member go to prison?		

Symptom	Past	Present	Symptom	Past	Present
Chronic sadness			Sleeping too little/too much		
Low frustration level			Difficulty falling asleep		
Crying episodes			Insomnia		
Irritability			Wakefulness		
Hopelessness			Nightmares		
Thoughts of suicide			Loss of appetite		
Difficulty concentrating			Over eating		
Weight loss			Binge eating		
Weight gain			Worry about being underweight		
Withdrawing from others			Worry about being overweight		
Difficulty functioning at work/school			Self induced vomiting		
Difficulty functioning socially			Laxative use		
Low energy/fatigue			Extreme exercising		
Reduced interest/pleasure			Self starvation		
Nausea/Vomiting			Obsessed with food		
Feelings of worthlessness/guilt			Obsessed with weight		
Difficulty making decisions			Difficulty waiting		
No interest in daily activities			Don't finish what you start		
Recurring thoughts of death or dying			Racing thoughts		
Extreme lows/highs			Constantly moving/pacing		
Shortness of breath			Taking on too much at once		
Pounding heart/palpitations			Difficulty starting a new task		
Avoid public places			Difficulty concentrating		
Trembling/shaking			Impulsive		
Agitation			Forgetfulness		
Fear of dying			Difficulty following directions		
Panic attacks			Grief/Loss		
Chest pain			Parent-child relationship issues		
Fearfulness			Financial concerns		
Avoid social situations			Infidelity		
Fear of leaving home			Communication problems		
Restlessness			Couple/Marital relationship issues		
Fear of loss of control			Self-harm/cutting		
Excessive worry			Sexual Problems		
Hearing voices/seeing things others do not			Anger Issues		
Fearful others are talking about you			Disaster		
Fearful someone is plotting against you			Terminal Illness		
Feelings of being followed/stalked			Health Problems		
Use marijuana to manage symptoms			Work burn-out		
Substance use causing problems with family/friends/work			Feeling detached from others/life		
Health problems/accidents due to substance use			Flashbacks/reliving bad experiences		
Others think I have a substance problem			Intrusive thoughts or bad memories		
Adult child of an alcoholic parent			Easily startled/upset		
Excessive use of alcohol/drugs			Feeling tense		
Fail at efforts to reduce use of alcohol/drugs			Hypervigilance		
Use of substances to cope			Feelings people are out to get me		
Legal problems related to substance use			Headaches		
Cigarette use causing health problems			Intestinal trouble		
Excessive gambling			Fatigue		
High risk sexual behavior			Trouble relaxing		
Pornography use			Body pain		
Prescription drug abuse			Stomach problems		
Drug abuse			Weakness		
Alcohol abuse			Tiredness		
Struggling with partner's addiction issues			Use CBD to manage pain		