Tensegrity
COUNSELING ASSOCIATES

Amanda L. Burke, Ph.D.
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 **$150 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:

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: _____

Tensegrity
COUNSELING ASSOCIATES

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

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.

Search Engines
It is not a regular part of my practice to search for clients on Google, Facebook, or other searchable sites. An exception could be during a crisis. If I have reason to suspect you are a danger to yourself or others and I have exhausted all other reasonable means to contact you and/or your emergency contact, then I may use a search engine for information to ensure your welfare. If this ever occurs, I will fully document the search and discuss it with you at your next session.

Location-Based Services
Please be aware if you use location-based services on your mobile phone you may compromise your privacy while attending session at my office. My office is not a check-in location on various sites such as Foursquare, however it can be found as a Google location. Enabled GPS tracking makes it possible for others to surmise you are a counseling client due to regular check-ins at my office location.

Business Review Sites
You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and

automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

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 Health Service Psychologist in the state of Oklahoma (#1354).

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:

Oklahoma State Board of Examiners of Psychologists
421 NW 13th Street, Suite 180
Oklahoma City, OK 73103
405-522-1333

Dr. Amanda L. Burke has satisfactorily supplied me with information regarding her practice, licensure, and professional development.

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

Tensegrity
COUNSELING ASSOCIATES

FEES FOR SERVICES

Initial Assessment and Testing per 90 minutes	$200
Individual Therapy per hour	$180
Missed Appointment/No Show/Late Cancelation fee	$150
Returned checks	$50

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	$150
➢ Court appearance *(minimum of 4 hours including commute & waiting)	$1500
➢ Each additional hour for court appearance	$400
➢ Preparation of reports for court (per 15 minutes)	$100
➢ 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: _____

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

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

Cell # _____

Via ☐ email message to the address listed here

Email address _____

Via ☐ 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: _____

Tensegrity
COUNSELING ASSOCIATES

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

Patient Name_____

I authorize Tensegrity Counseling Associates to use my credit card details for charges incurred for: _____ (*Patient Name*), which includes missed session fees. This agreement will be in effect until I revoke this agreement in writing to: Tensegrity Counseling Associates, 1733 W 33rd St., Suite 120, Edmond, OK 73013.

I understand that if this agreement is not paid as agreed it will be turned over for outside collections and all collection agency's fees and attorney's fees will become patient responsibility.

_____ _____
Responsible Party Signature Date

(*Circle one*) Visa / MasterCard / Discover

_____ _____/20____
Credit Card Number Expiration Date
Security Code _____

_____
Cardholder Name as Appears on Card

_____
Billing Address Associated with Card City Zip Code

Tensegrity
COUNSELING ASSOCIATES

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

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 ☐ Website ☐ 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:

If student, where do you attend school?

_____

What grade are you in?

_____

Demographic Information:

Ethnic/Racial background: _____

Sexual Orientation: _____

Religious/Spiritual background: _____

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

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

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Health Background:

List all current medications and dosages, including supplements:

Name	Dose	How often	Reason for	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 been physically abused?		
Have you ever been emotionally abused?		
Have you ever been verbally abused?		
Have you ever been sexually abused or sexually assaulted?		
Have you ever witnessed violence or a tragic event?		
Have you ever attempted suicide?		
Have you ever put yourself in harmful situations?		
Have you ever injured yourself?		
Have you ever acted out sexually?		

Have you ever wanted to severely hurt or kill someone else?		
Have you ever acted aggressively towards others?		
Is there a history of alcohol or drug problems in your family?		
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?		

Does your child show unusual behavior (explain)?

_____
_____
_____
_____
_____

If school age, what does your child's teacher say about him/her?

_____
_____
_____
_____
_____

Please indicate if you are currently, or have in the past, experienced problems with any of the following:

Symptom	Past	Present	Symptom	Past	Present
Fighting			Self harm/cutting		
School suspension			Bed wetting		
School expulsion			Going to the bathroom in pants during the day		
Lack of friends			Acting out sexually		
Learning disabilities			Chronic lying		
Incomplete homework			Stealing		
Alcohol or other drug use			Trouble with authority figures		
Skipping class			Trouble specifically with male adults		
Difficulty concentrating or focusing			Trouble specifically with female adults		
Gang influence			Overly sensitive		
Poor attendance			Crying episodes		
Behavior problems			Difficult to console when upset		
School detention			Socially awkward		
Poor grades			Withdrawn from others		
Conflicts with teachers			Chronic sadness		
Conflicts with peers			Angry outbursts		
Eating more			Excessive worry or fear		
Eating less			Impulsive		
Binge eating			Fire setting		
Purging after eating			Cruelty to animals		
Self starvation			Exposure to pornography		
Sneaking food			Grief/Loss		

Weight loss				Parent--child relationship issues			
Weight gain				Disaster			
Sleeping too little/too much				Headaches			
Difficulty falling asleep				Intestinal trouble			
Insomnia				Fatigue			
Wakefulness				Trouble relaxing			
Nightmares				Body pain			
Teeth grinding				Stomach problems			
Jaw clenching				Weakness			
Pornography use				Tiredness			
Compulsive masturbation							