Tensegrity
COUNSELING ASSOCIATES

***Mary Beth Nelson, LPC-S, RPT***
**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 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 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 neglect, physical or sexual abuse of a child or an elder or individual with a disability; 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 **$100 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: _____**

**Photography of client / artwork / sand tray / creation**

I give my permission for the therapist to photograph the client's artwork, sand tray, creation if requested by the client. These photos will be shared with the client or parent and will become a part

of the client record.

**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: _____**

**Telemedicine Services**

I have agreed to participate as a client on the **https://www.gotomeeting.com** Telemedicine (telehealth, teletherapy, distance therapy, e-therapy, internet therapy, or online therapy) network. I will be receiving health care services through interactive video (computer, cell phone, tablet) or telephone equipment. I understand my participation in this is totally voluntary and I may decide to stop at any time. Telehealth is governed by the same laws that protect the confidentiality of your medical information that cover in-office, in-person, face-to-face psychological services. I understand that my provider will deliver telemedicine services from a secure location that safeguards my confidentiality. I understand that it is my responsibility to select a safe and secure location to receive telemedicine services. The patient and psychotherapist both agree to keep the same privacy safeguards during a telemedicine session. No electronic transmission system is considered completely safe from intrusion. Interception of communication by third parties remains technically possible. Due to the complexities of electronic media and the internet, risks of telehealth include the potential release of private information, including audio and images. You are responsible for information security on your device. As a policy, we ask for your agreement to not electronically record telehealth sessions without prior written consent. Telehealth can also include telephone sessions. If you are using a cellular telephone, remember that not all calls or telephones are completely secure and may be compromised by various detection devices. A landline is preferable because is more secure, reliable, and often offers clearer audio quality. Telehealth is not recommended for a psychological emergency and are only provided when it is unlikely that a mental health emergency could arise during the session.

I give my consent to receive psychotherapy services over the telehealth. I understand the services I receive will become part of my treatment record. I have read this document and I hereby consent to participate in telemedicine network under the terms described above.

**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: _____

## INFORMED CONSENT FOR IN-PERSON SERVICES DURING

## COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

### Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, 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, so that is an issue we may also need to discuss.

### Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

### 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 10-15 minutes before our appointment time. I will come to the door and let you in at 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, please 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 and we have posted our efforts on our website and in 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 must 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.

**Informed Consent**
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

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

Signature: _____ Date: _____

Printed Name: _____

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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.

**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 Professional Counselor (LPC) by the Oklahoma State Board of Behavioral Health, license number 5177 and a Registered Play Therapist, license number T4861.

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
Fax: (405) 271-1918
Website: www.ok.gov/behavioralhealth

Association for Play Therapy
401 Clovis Avenue, Suite 107
Clovis, CA 93612
559-298-3400
559-298-3410
https://www.a4pt.org/

Mary Beth Nelson, M.Ed., LPC-S, RPT 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 | $150 |
| Missed Appointment/No Show/Late Cancelation fee | $100 |
| 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) | $1200 |
| ➢ Each additional hour for court appearance | $300 |
| ➢ Preparation of reports for court (per 15 minutes) | $75 |
| ➢ Emergency appearance (less than 14 days notice) | $400/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.

Client's 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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**Patient Name**_____

My credit card / debit information will be entered and saved in the HIPPA-secure Ivy Pay (Ivy Labs, Inc.) credit / debit card option. I authorize Tensegrity Counseling Associates to use my credit card details for charges incurred for: _____ (*Patient Name*), which includes fees for services and missed session fees ($100). I understand that I will receive a notification / receipt when there is a transaction through Ivy Pay.

This agreement will remain 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 the client's fees for services / missed session fees are 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

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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: _____ ☐ Male ☐ Female ☐ Transgender

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? ☐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?

_____

Student, 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: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

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**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

Do you have a gluten allergy or sensitivity? ☐ Yes ☐ No

Do you have a dairy allergy or sensitivity? ☐ Yes ☐ No

Do your take vitamins? ☐ Yes ☐ No

Do you use Rogaine / Minoxidil? ☐ Yes ☐ No

Do you take Singulair or Topamax ☐ 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? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Do you snore or sleep with an open mouth? _____

List any allergies you have: _____

Approximate date of your most recent physical examination: _____

Was blood work taken? ☐ Yes ☐ No

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? | | |
| Are you currently having suicidal thoughts / ideation? | | |
| 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? | | |

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

| 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 | | |
| | | | 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 | | | | | |