

PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

Please initial each section indicating you have read and understand the following information.

Experience:

My name is Debbie Guedry and I am a Licensed Professional Counselor. I have counseled children, adolescents, adults, and families in various settings including non-profit agencies, schools, and private practice. I have experience in treating various mental health issues including depression, anxiety, family and/or relationship issues, vocational guidance, life changes/transitions, grief, substance abuse and stress management.

Nature of Counseling:

I will utilize various therapeutic interventions, such as cognitive behavioral, individual psychology, reality therapy, solution-focused, and non-directive play therapy approaches. The therapeutic approach is determined by the client's individual needs and situation. Our therapeutic relationship will be an important part of the counseling process and should be one of cooperation and equality. During counseling I will strive to gain insight by examining past experiences and current life strategies. Through insight, encouragement, and action, the goal of treatment will be to help the client move towards self-realization and personal growth.

INFORMED CONSENT

Counseling Relationship:

During the time you and I work together, we will meet at previously scheduled times for 50-minute sessions. Although our sessions may be very personal psychologically, ours will be a professional relationship rather than a social one. Our contact will be limited to counseling sessions you arrange with me. In case of an emergency you should call 911 or go to your nearest emergency room. Please do not invite me to social events, offer gifts, ask to barter or exchange services, and ask me to write references/recommendations for you, or ask me to relate to you in any way other than the professional context of our counseling relationship. You will benefit the most if our interactions address your concerns exclusively.

Potential Benefits of Counseling:

- Increased self-awareness and education about domestic violence and/or relationship violence
- Increased awareness of choices in one's life, relationships, etc.
- Opportunities for personal growth and to develop and practice new skills in a supportive environment
- Support in reaching personal goals

Potential Risks of Counseling:

- Participation in counseling may contribute to your choice to change some of your behaviors. There is a potential risk that significant others in your life may not be supportive or approving of the changes you choose to make. Both personal safety and personal choice will be emphasized throughout your counseling experience.
- Personal growth sometimes includes periods of discomfort. Participation in counseling may contribute to remembering difficult events and experiencing intense feelings. I can be a resource during these times by helping you establish individualized safety plans and coping skills.

Client Rights:

You have the right to:

- Safety and safety planning
- Recognition of your interests and self-determination
- Respect and protection of your civil and legal rights
- Privacy and confidentiality within the rules and regulations
- Compassion and acceptance without opinion or judgment
- Services provided in an empowered-based environment, without attribution of blame
- Personalized services and information, including referrals and resources
- Refusal of any services offered
- Be treated with respect and dignity
- A supportive, positive environment that ensures safety, respects boundaries, and values the health and well-being of every individual
- A healthy and empowering counseling environment

Postponement and Termination:

I reserve the right to postpone and/or terminate counseling of any client who comes to a session under the influence of alcohol or drugs. I also reserves the right to discontinue counseling of any client who does not comply with the medication recommendations of a psychiatrist or physician. If addiction is an issue, the client is strongly recommended to attend a 12 step program in conjunction with counseling. If client refuses, termination will be discussed.

Cancellations: In the event you are unable to keep an appointment, please call or text me at 512-963-6924, at least 24 hours in advance. If this request is not followed, you will be financially held responsible for the missed appointment at the regular hourly rate. This number is for brief communication for scheduling or canceling appointments only.

Telehealth Consent: This is to confirm that the client is aware that there are policies and limitations to to telehealth and digital therapy (email or voicemail).

1. CONFIDENTIALITY: The therapist is required to confirm that the video platform is HIPAA compliant (except during states of Emergency or when the government mandates otherwise). The therapist cannot be held responsible to maintain confidentiality if the client allows others to enter the therapy space. If the client is feeling that confidentiality is being compromised at any time during the session, then it is the responsibility of the client to inform the therapist.
2. If the connection during a session is discontinued, the client and the therapist will continue to make effort to contact each other to close the session. The phone numbers will be provided and agreed to prior to therapy initiation. Failure to comply could lead to termination of services.
3. The emergency policy and confidentiality limitations listed in the consent are still valid and applied to telehealth and digital therapy.
4. The fees for telehealth service are the same as office fees.
5. To maintain confidentiality, there is absolutely no permission to share written or recorded session information of any kind in any way. Including, but not limited to any social media, email, or person. If you need to share information, you may request a release of information in writing.
6. Telehealth therapy may be discontinued if there is no ability to maintain an appropriate connection. An alternate plan will be created at that time. All other standard policies regarding appointments and/or termination remain in place.

Referrals:

I recognize that not all conditions presented by clients are appropriate for treatment by me. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling is available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Fees: My fee is \$100 per hour for individuals, \$125 for couples, and \$150 for families. If I am called to testify in court, my fee is \$1200 for a full day and \$600 for a half-day. You will be billed at my hourly rate for all services provided to include conferences, telephone conversations, preparation of documents, preparing for and giving a deposition, preparation for and appearance in court, and other tasks necessary to adequately handle your needs. My hourly rate also applies to the time taken to speak to, send correspondence to, and respond to correspondence from your legal representative. **I accept cash, check, Venmo and Zelle.**

Ethics:

Services will be rendered in a professional manner consistent with accepted ethical standards. While it is impossible to guarantee any specific results regarding your individual goals, together you and I will work to achieve the best possible results for you.

Contacting me

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, go to your Local Hospital Emergency Room, or call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

Records and Confidentiality:

All of our communication becomes part of the clinical record. Any confidential information must be communicated in a face-to-face situation. Do not leave such information on a voicemail recording; do not send such information in an e-mail or text message. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of seven years after the client's 18th birthday. Most of our communication is confidential, but the following limitations and exceptions do exist: a) you are a danger to yourself or someone else; b) suspected abuse, neglect, or exploitation of a child, elderly, or disabled person; c) you disclose sexual contact with other mental health professional; d) I am ordered by a court to disclose information; e) you request release of your records; or f) I am otherwise required by law to disclose information. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first. In the case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge any secret to be detrimental to the therapeutic process.

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In the event that I believe you are in danger, physically or emotionally, to yourself or another person, you specifically consent for me to warn the person in danger and to contact the following persons listed below, in addition to medical and/or law enforcement personnel:

Name

Telephone Number

Your signature below indicates that you have read and understand this statement and that any questions you had about this statement were answered to your satisfaction, and you have received a copy of this statement. **My signature verifies the accuracy of this statement and acknowledges my commitment to conform to its specifications.**

Client's Signature

Counselor's Signature

Date

Date

**Adolescent Consent Form
&
Parent Agreement to Respect Privacy**

What to expect:

The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

>You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.

> You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.

>You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

>You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Virginia Department of Social Services.

>You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.

Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

[You should also know that, by law in Virginia, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.]

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

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**Adolescent Consent Form
&
Parent Agreement to Respect Privacy**

Adolescent therapy client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature _____ Date _____

* * *

Parent/Guardian:

Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

Although I know that in this state I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

I understand that I will be informed immediately about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent Signature _____ Date _____

Parent Signature _____ Date _____

Therapist Signature _____
Date _____