CLIENT INFORMATION & TREATMENT AUTHORIZATION

ANNE MINITER MCKAY COUNSELING, LLC LICENSE#0701004304
487 B CARLISLE DRIVE, HERNDON, VA 20170
INFO@ ANNEMCKAYCOUNSELING.COM VOICE/TEXT: 703-328 4937

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ City: _____ State: _____ Zip Code:_____

Cell Phone: _____ Date of Birth: _____ Age: _____ Referred by: _____

Current Occupation: _____ Highest Level of Education: High School/College/Graduate School

Email: _____

Prior Counseling: Yes / No Most recent treatment date: _____Provider Name: _____

Your Nuclear Family:

Name: Age: Relationship to You: Currently Resides With You?

_____

_____

_____

_____

_____

- Current Marital Status (circle one): Married / Divorced / Separated / Co-Habitating Since date:_____
- Father's Age: _____ Mother's Age: _____ Were you adopted? Yes /No If yes, adoption age? _____
- Parent's Marital Status (circle one): Married / Divorced / Separated since date: _____

Please answer the following questions as accurately as possible. All information is confidential:

1. Current and/or Past Psychological Behavioral Episodes (e.g. Depression, anxiety, bipolar disorder, etc.):

Condition: Approx. Dates Start to Finish:

_____

_____

2. Current Psychiatric Medication Taking:

Medication Name: Prescribed to Treat:

_____

_____

3. Biological Family History of Episodes of Behavioral Disorders (e.g. Depression, schizophrenia, bipolar disorder, etc. in siblings, parents, grandparents):

Condition: Biological Relationship to Client:

_____

_____

- Do you engage in any types of high-risk or self-injurious behavior?: *Yes No*
- Have you ever attempted suicide? *Yes No*

- Any family members attempted or completed suicide? Yes No Describe:
  _____
- Do you have any suicidal thoughts or plans now? Yes No
- Are there weapons in the home? Yes No
- Have you ever been involved with the legal system? Yes No Describe:
  _____

4. Past Major Physical Health Problems and/or Disabilities:

_____

_____

Your Main Reason for Seeking Counseling:

_____

_____

_____

Information regarding my policies on protected health care information as per Virginia law and HIPPA can be found on my website below. If you have any questions regarding this information, please ask me. Thank you. www.annemckaycounseling.com – Click on HIPPA link on the front page.

I, the below named client, authorize individual psychotherapy treatment for myself (or my above named child under the age of 18):

_____ _____
Signature Date

Please Print Name: _____

Emergency Contact: _____Telephone: _____Relationship: _____

****

_____ _____
** 2nd Parent Signature required if parents are divorced or separated Date

Please Print Name: _____

[*Revised 6/2017*]

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Adult Client-Therapist Treatment Agreement

Thank you for selecting me as your therapy provider. I will do all I can to offer you the highest quality care possible. The purpose of this Client-Therapist Treatment Agreement is to provide you with important information about the counseling process and your rights and responsibilities. Counseling is more likely to be successful if we have a mutual understanding of the treatment process.

Within the next few sessions, we will establish goals for our work together and plan a treatment that seems likely to help you achieve those goals. I have found counseling to be most effective if we work collaboratively; I expect you to come to our sessions on time, to complete any tasks we agree upon, and to do your best to talk about the concerns, behaviors, thoughts, and feelings that are bothering you. Although counseling usually results in positive changes in mood, behavior, relationships and other areas, it may also lead to unanticipated and unwanted changes. If anything about our counseling troubles or disappoints you, I strongly encourage you to talk about that in our sessions so that we can address your concerns. You have the right to full information about your treatment and to plan an active part in that treatment. You have the right to receive a copy of the code of ethics that I follow, to ask questions about the counseling process, to express your concerns, to obtain a second opinion, and/or to terminate counseling.

Confidentiality, one of your most important rights, is maintained as part of the counseling process in accord with the ethical standards of my profession. Your written authorization is required for release of information or records, such as to your physician. **Exceptions are made to this policy on confidentiality only in the event of court order, clear and imminent danger to you or another person, or suspected abuse of children, the disabled, or the elderly.** An exception also can be made in the event of nonpayment of fees necessitating the use of a collection agency; that agency will not receive information on the content of our work, but may need to receive dates of sessions and copies of your consent to treatment forms. In addition, I sometimes consult with peers, but will not provide any identifying information about you in the course of consultation. I use an encrypted computer and my email is password protected, but the security of electronic communications can never be completely guaranteed. A note about Facebook: I do not accept friend requests from clients because it jeopardizes your confidentiality. If you are concerned about confidentiality matters with the use of email or other electronic communications, please always call me.

My current fee is $160 for a 45 minute session and $260 for a 75 minute session. Payment should be made at the time of service. I will provide you with monthly statements for your submission to insurance. A charge of $40 per 15-minute segment also will be made for consultation by telephone. No charge will be made for brief telephone conversations to schedule, change, or confirm appointments. Court testimony is not encouraged to include participation from this practice. Any participation from this practice will occur only under official Court Summons which must be served at this address. Fees charged for this activity will be 1 hour driving time for each way and a minimum of 1 hour testimony time, both at the rate of $320/hour.

If you need to cancel or change an appointment, please give me at least 24 hours notice. If that is not done, you will be charged in full price for any missed appointments. ***Emergency Cancellations (within 24 hours)*** due to a family emergency or some other unforeseeable infrequent circumstance should be made by call or text to my cell number. These appointments will be a courtesy reschedule. You will not be charged for weather-related cancellations if area schools are closed due to the weather at the time of your appointment.

I will provide you with my contact number as well as email address. Texts may be sent and/or messages may be left on my voice mail at any time. I regularly check these contact points and will return your outreach as soon as possible. Please note that I do not respond to counseling related issues via email or text as concerns in these areas are best handled in session.

Facetime and/or Skyping as a form of ongoing support and/or transitional support, will only be provided at my sole discretion and with prior extensive counseling established via in-person in office treatment.

In the event of a true emergency, please go to the nearest hospital emergency room or call the nearest community mental health center. **If the emergency involves a life-or-death situation or threat of physical harm, contact me AFTER calling public emergency numbers and your psychiatrist's emergency number (if you have one) or proceed to the nearest hospital emergency room.** These could include the following 7 day a week, 24 hour a day numbers: 911 (any area); Colombia Dominion Hospital, 703-536-2000; Fairfax/Falls Church Community Mental Health Center at Woodburn, 703-573-5679; or Inova Fairfax Hospital 703-698-1110. Please do not use email or text for emergency situations.

Information regarding my policies on protected health care information as per Virginia law and HIPPA can be found on my website below. If you have any questions regarding this information, please ask me. Thank you.

www.annemckaycounseling.com – Click on HIPPA link on the front page.

Please sign below to indicate that you have reviewed, understand, and are in agreement with the policies in this statement. Please keep one copy for yourself and return the other to me.

_____
Client (Printed Name)

_____ _____
Signature/Parent Signature (Date)

****

HIPAA Acknowledgement:

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Signed and Received by :_____

Print Name: _____

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