What You Should Know About Counseling

What is counseling?

The word "counseling" is interchangeable with the word "therapy".

Counseling is a relationship in which a professionally trained person (therapist) helps you to better understand yourself and solve problems. Seeking counseling is not a sign of weakness. Many people find that professional assistance is a mature and positive step toward success.

Counseling takes place in a private, secure, uninterrupted setting.

Counseling is a collaborative process in which the therapist acts as a facilitator so that awareness and change can take place. One goal is for you to learn new skills to help you resolve your current problems and become more capable of solving new problems on your own in the future.

Counseling involves talking about yourself, including your family and personal history as well as your thoughts and feelings.

Counseling is also referred to as "therapy" or "outpatient mental health services".

What to expect in the first session

After you have scheduled your first appointment, you may find yourself experiencing anxiety and wondering what you will talk about. This worrying is normal. Therapists are aware that meeting with a "stranger" to discuss personal concerns can be intimidating. Remember that your therapist is a trained professional who will work at establishing a comfortable and supportive environment for you. Your therapist will want to focus on you and may ask you a number of questions about yourself, your history and your current problems. An appointment "hour" is typically 53+ minutes and is scheduled on a weekly basis to begin with. Your therapist will also discuss your insurance coverage and/or payment arrangements with you. If the therapist determines that you would benefit from additional services, this will be discussed with you and referral(s) made.

What is expected of you?

To attend sessions and let your therapist know 24 hours in advance if you will need to cancel and/or reschedule an appointment.

To talk openly and honestly about yourself.

To complete tasks or homework assignments.

To let your therapist know if you have questions about the counseling or feel that you are not making any progress.

To let your therapist or the business office know if you are having difficulty paying your bill.

What is a Treatment Plan?

During the course of counseling, the therapist develops a written Treatment Plan which is a plan of action based on the principles, methods and theories of counseling. The Treatment Plan is aimed toward the prevention, treatment and resolution of problems and/or mental health disorders. The plan includes a descriptive statement of each problem and specifies goals, objectives and interventions. The purpose of a written Treatment Plan is to document the course of treatment, provide a structure for measuring progress, and allow for accountability. Client collaboration and cooperation is important for developing and complying with the Treatment Plan.

How is therapy paid for?

Depending on the type of education and experience of the provider, fees can range from $50 to $200 an hour. Many people have health insurance that includes some type of coverage for mental health services. You can discuss your coverage with your insurance company, human resource person at your place of employment, or with the therapist. Often, insurance covers a large portion of the fee and you have a co-pay. Managed care insurance plans may require authorization for services. You must sign an Authorization for Treatment and Billing Services form in order for us to bill charges to your insurance plan. If you are uninsured, your insurance does not cover counseling, or you chose not to use your insurance, you are responsible for full payment at the time of service. It is acceptable to discuss payment arrangements (credit card, special arrangements for payments, collection practices) with your therapist. If you would like to use a credit card to pay for services, you must complete a Credit Card Payment Consent form. This allows us to bill your credit card for services rendered. If you would prefer to pay by credit card without our involvement, you can do so by logging onto professionalcharges.com, selecting the "Make A Payment" button and completing the Payment Form. You will need to enter the Lakeview Counseling Tax I.D. number — 383269851.

Charges will appear on your credit card statement as "ProfessionalCharges.com".

Understanding the different types of therapists

Psychiatrists are medical doctors (M.D. after the name). They have completed medical school and a residency in psychiatry. They are able to write prescriptions and administer medication(s).

Psychologists have a Doctorate degree in psychology (PhD after the name) and are licensed to practice in their state. They have completed graduate school, including a doctoral program. They are able to provide a variety of forms of testing and therapy.

Social Workers have completed a Master's degree in Social Work (MSW, LMSW, or ACSW after the name). They are licensed to practice in their state and have unique training in order to provide services for individual and family problems.

All therapists at Lakeview Counseling have completed the following education and training requirements: completion of a Master of Social Work degree or a PhD in Clinical Psychology; completion of a minimum of 5 years postgraduate supervised clinical experience; licensure as a "Certified Social Worker" or "Clinical Psychologist" with the State of Michigan; membership in the National Association of Social Workers or American Psychological Association; acceptance into the Academy of Certified Social Workers; and participation in continuing education activities.

To file a complaint about a therapist, you can contact the State of Michigan, Department of Community Health, or the national association in which the therapist has membership.

What You Should Know About Confidentiality

The security and confidentiality of all records is protected by both Federal and State law. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) outlines regulations related to the release of information about you.

What is protected:

Any information about a person's health, health care or payment of health care — this includes mental health and behavioral health issues; information that identifies a person; information created or received by a covered health

care plan or provider; and all medical records and other individually identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally.

Protected health information may not be disclosed by the clinic or a therapist without the informed and voluntary written consent or authorization of the client.

The clinic is required to obtain a client's consent for use or disclosure of client information for purposes of health care treatment, payment and operations.

Any conversations or communications you have with your therapist are private and confidential except under the following circumstances:

- disclosures required by law
- disclosure about victims of abuse, neglect or domestic violence
- emergency circumstances
- identification of the body of a deceased person or the cause of death
- permitted disclosures for public health activities (e.g.: reporting diseases, collecting vital statistics)
- research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board
- oversight of the health care system
- limited law enforcement activities
- judicial and administrative proceedings
- disclosure to avert a serious threat to health or safety; activities related to national defense and security
- case consultation (client name and demographics are not disclosed)
- audited review by your insurance carrier
- malpractice complaint or investigation

Please be aware that psychotherapy notes are held to a higher standard of protection because they are not part of a medical record and are never intended to be shared with anyone else.

Client Registration (Minor)

LEGAL NAME: _____ Today's Date: _____

Date of Birth: _____ Age: _____

The minor identifies their gender as: _____ Pronouns? _____

Street Address: _____ Email address: _____

City: _____ State: _____ Zip: _____

BEST Contact Phone Number: _____ Contact Person: _____

CONTACT IN CASE OF EMERGENCY:

Name: _____ Phone: _____

Father's Name: _____ Address _____
Phone: _____

Mother's Name: _____ Address _____
Phone: _____

If child is NOT living with either parent, Name and Address of Guardian(s):

_____

_____

Name/age of others living in the home: _____

_____

_____

Email of Parent/Guardian _____

Developmental History:

When the mother was pregnant with this child, did she have (check all that apply):

☐ Excessive wight gain ☐ Bleeding or spotting ☐ High blood pressure

☐ Measles, Mumps or Chicken pox ☐ Use of alcohol ☐ Use of nicotine

☐ Use of drugs ☐ Other_____

Any complications during labor and delivery?

_____

_____

_____

Was the child premature? YES [☐] or NO [☐]

Did the child spend time in the hospital after birth? YES [☐] or NO [☐]

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Details:

Any concerns about child's developmental milestones (sitting, crawling, walking, talking, etc.)?

PHYSICIAN: _____ PHONE: _____

Date of Last Physical Exam: _____

Was the child sick but failed to get medical care in the last year? YES [ ] or NO [ ]

Please list all MEDICATIONS the child is now taking. Include those purchased without a doctor's prescription:

Medication Name	Dosage/ Frequency	Medication Name	Dosage /Frequency

Please list any ALLERGIES that the child has: _____

Has the child had (Please check any that apply):

[ ] Asthma	[ ] Attention Deficit Disorder	[ ] Cancer
[ ] Chicken Pox	[ ] Diabetes	[ ] Epilepsy/Seizures
[ ] German Measles	[ ] Hearing Problems	[ ] Heart Problems
[ ] Measles	[ ] Migraines	[ ] Mumps
[ ] Polio	[ ] Pregnancy	[ ] Problems with alcohol/drugs
[ ] Problems with eyesight	[ ] Problems with weight/eating	[ ] Rheumatic Fever
[ ] Roseola	[ ] Scarlet Fever	[ ] Sexual assault/molestation
[ ] Sexually Transmitted Disease	[ ] Tuberculosis	[ ] Whooping cough

[ ] Other: _____

Has the child ever been hospitalized? YES [ ] or NO [ ] If yes, please explain: _____

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Family Health History

Please provide the following information about the child's immediate family:

Family Member	Age if living	Age at death	Status of Health or Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			

Illness (indicate which family member(s)):

Alcoholism _____
Anxiety Disorders _____
ADD/ADHD _____
Bipolar/Manic Depression _____
Blood Disease _____
Cancer _____
Dementia/Alzheimer's _____
Depression _____
Diabetes _____
Drug Dependence _____
Epilepsy _____
Glaucoma _____
Heart Disease _____
High Blood Pressure _____
Parkinson's Disease _____
Rheumatoid Arthritis _____
Schizophrenia _____
Thyroid problems _____
Tuberculosis _____

Other illness(es): _____

_____

School Information

Is child currently in school? YES ☐ or NO ☐ Name of School: _____

Grade Level: _____ Any grades skipped? _____ Any grades failed? _____

Has the child been in special education classes/programs: YES ☐ or NO ☐

If YES, please explain: _____

_____

Did the child miss more than ten days of school last year due to illness: YES ☐ or NO ☐

Does the child have any of the following problems in school? Please check all that apply:

☐ Aggression ☐ Bullying ☐ Difficulty completing assignments

☐ Difficulty following directions ☐ Disorganization ☐ Relationships with adults

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☐ Relationships with peers ☐ Shy / Withdrawn ☐ Tardiness

☐ Tired/lack of energy ☐ Truancy/ Unexcused absences

Legal History

Has the child ever been arrested? YES [ ] or NO [ ]

If yes, please explain: _____

Has the child ever been on probation? YES [ ] or NO [ ]

If yes, please explain: _____

Is the child currently on probation? YES [ ] or NO [ ]

If yes, please explain: _____

County of probation: _____ Name of probation officer: _____

Social Information

Languages other than English spoken in the home: _____

Do you know or suspect that your child is harming him/herself physically? _____

_____

Please list any of the child's stressful life experiences and include dates: _____

_____

_____

Organized activities in which child participates (ie: sports, scouts, clubs, music, camp, youth group (please list):__

_____

_____

Current Problems

Please state the reason(s) you are seeking services at this time: _____

_____

_____

_____

Has the child been involved in counseling before? YES [ ] or NO [ ]

If yes, please explain: _____

_____

How did you learn of Lakeview Counseling? _____

_____

_____ _____

Signature of parent/legal guardian completing this Registration Date

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Problem Behavior Inventory for: _____ Date _____

Please mark any problems that apply to the child

- ☐ Abnormal sexual development
- ☐ Abuse, physical
- ☐ Abuse, sexual
- ☐ Academic difficulties
- ☐ Alcohol use/abuse
- ☐ Anxiety, fears, phobias
- ☐ Attention seeking behaviors
- ☐ Argumentative
- ☐ Autistic
- ☐ Avoids physical contact
- ☐ Behavior problems in school setting
- ☐ Bossy
- ☐ Bullies/ intimidates others
- ☐ Low concentration/distractible
- ☐ Clingy, insecure
- ☐ Clumsy
- ☐ Compulsive exercise
- ☐ Conflicts with parents/authority
- ☐ Cries easily, whines
- ☐ Cruelty to pets or children
- ☐ Dawdles/lingers in dressing, eating, bedtime, homework, chores
- ☐ Daydreaming
- ☐ Death/loss of loved one
- ☐ Dependency
- ☐ Depression
- ☐ Destruction of property
- ☐ Developmental delays
- ☐ Divorce (parents)
- ☐ Drug use/abuse
- ☐ Eating (binge/purge/starvation)
- ☐ Elective mutism
- ☐ Encopresis (soiling self)
- ☐ Enuresis (urinating at night or in clothing)
- ☐ Engages in dangerous/risky behavior
- ☐ Fire setting
- ☐ Forgetful
- ☐ Health/medical problems
- ☐ Humiliated/shamed
- ☐ Hyperactivity
- ☐ Hypochondriasis
- ☐ Imaginary playmates/fantasy
- ☐ Isolation, withdrawal
- ☐ Learning disability
- ☐ Legal difficulties
- ☐ Low self-esteem
- ☐ Lying
- ☐ Name calling
- ☐ Need for supervision at home
- ☐ Neglected
- ☐ Nervous habits (i.e: nail biting)
- ☐ Nightmares/night terrors
- ☐ Non-compliance
- ☐ Poor toilet training/habits
- ☐ Obsessive
- ☐ Odd facial grimaces
- ☐ Oppositional
- ☐ Overactive/restless
- ☐ Relationships
- ☐ Removed from biological parent(s)
- ☐ Repetitive behavior/compulsions
- ☐ Running away, wandering off
- ☐ Sleep problems
- ☐ Self-abusive behavior
- ☐ Separated from siblings
- ☐ Sexual acting-out with others
- ☐ Sexually oriented play

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☐ Shyness
☐ Speech difficulties
☐ Steals
☐ Swearing
☐ Temper tantrums
☐ Thumb sucking
☐ Tics
☐ Victim of sexual abuse
☐ Victim of rape or sexual assault
☐ Perpetrator of sexual abuse
☐ Perpetrator of sexual assault

Please indicate how we may contact you:

Home phone: _____
_____ I give consent to leave messages on my voicemail.
Initial

Work phone: _____
____ I give consent to leave messages on my voicemail.
Initial

Cell Phone: _____
____ I give consent to leave messages on my voicemail.
Initial

Email: _____
____ I give consent to send messages to my email address.
Initial

It is important to be aware that there are uncertainties related to the privacy and confidentiality of electronic communications. It is not advisable to use email or text for emergency situations. Emails and texts maintained as part of the client record. Lakeview Counseling, PC, is not liable for any breaches of confidentiality caused by the client or any third party.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS INFORMATION. I UNDERSTAND THE RISKS ASSOCIATED WITH THE COMMUNICATION OF EMAIL AND/OR TEXTS BETWEEN MY THERAPIST AND MYSELF AND CONSENT TO THE CONDITIONS OUTLINED.

Client Name: _____

Client Signature: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

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Lakeview Counseling adheres to the following policies regarding provision of services to children whose parents are divorced or in the process of divorce.

1. Parents with *legal custody* have the right to know that their child is receiving counseling services, the name of the provider and any relevant clinical information. Involvement and input from each parent is welcomed and can contribute greatly to the success of counseling.

   Initial:

   _____ The child lives with both parents, who have full legal custody.
   _____ I have sole legal custody of the child.
   Lakeview Counseling may request proof that a parent has *legal custody*.
   _____ I have joint legal custody *

   _____ Other: ☐ Foster Parent ☐ Legal Guardian

   * The Name and address of the other parent with legal custody of the minor child:
   Name of Parent: _____
   Street Address: _____
   City: _____ State: _____ Zip: _____
   Phone Numbers with Area Code(s): _____

2. The parent/guardian giving permission for treatment is responsible for all therapy costs outside of those covered by a health insurance plan or other third party entity. Lakeview Counseling does NOT bill parents separately for portions of shared costs. **Parent/Guardian's initials** _____

Authorization For Treatment And Billing Services

CLIENT NAME: _____

Date of Birth: _____

If minor child, name of Parent/Guardian: _____

I understand the following:

- I am requesting outpatient mental health services at Lakeview Counseling.
- These services are confidential and information cannot be released without my written consent.
- If I feel my civil, treatment, or personal rights have been violated, I can report it to the State of Michigan, and/or the Department of Mental Health, and/or the Department of Commerce.
- I am fully responsible for paying any fees not covered by my insurance company or other third party payment source.
- Payment is required at the time of service unless other arrangements have been made.
- A monthly late fee may be charged if monthly payments are not received.
- I must inform Lakeview Counseling of any changes in my insurance benefits.
- I must give a minimum of 24 hours notice if I cancel an appointment. Failure to do so may result in a $50.00 fee. Failure to keep an appointment may result in a $50.00 fee.
- Accounts which are delinquent will be subject to a collection process.

- I must inform Lakeview Counseling of any changes to my contact information (i.e. address, name, phone numbers, etc.)

I authorize the release of any information necessary to process insurance/billing claims as well as payment of all Mental Health insurance benefits to be made directly to Lakeview Counseling. I have received the Notice of Privacy Practices and have been provided with an opportunity to review it. I have been provided with the HIPAA information.

Client or Parent/Guardian Signature _____ Date _____

Spouse Signature (if conjoint therapy is taking place) _____ Date _____

For Treatment Of Person(s) Under The Age Of 18

Based on the laws of the State of Michigan and the guidelines of the therapist's profession, the rules concerning privacy will be used. I can maintain contact with the therapist via telephone or per a scheduled appointment time. I can request a written report or summary of services provided to the minor. I agree that I am the parent accepting responsibility for provision of insurance or other third party information and the payment of fees. I understand that Lakeview Counseling cannot charge or bill any other parent, guardian or third party entity without their permission.

My signature below means that I understand and agree with the points stated above.

I, _____, the parent/legal guardian of the minor, _____ give my permission for this minor to receive therapy services at Lakeview Counseling, PC.

Client or Parent/Guardian Signature _____ Date _____

Billing Information

CLIENT NAME: _____

Address: _____

City:_____ State:_____ Zip Code: _____

Telephone: _____

PRIMARY INSURANCE: _____

Contract #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____ SS#: _____

Subscriber's Relationship to Client: _____ Subscriber's Employer: _____

Subscriber's Address if different than client's: _____

OFFICE USE:

Date Called: _____ Spoke with _____

Policy Year: Calendar/Renewal Month _____ COB? YES [ ] or NO [ ]

Deductible: _____ Deductible amount met: _____

Co-pay/ins: _____ Unlimited Visits: YES [ ] or NO [ ]

Authorization Required: YES [ ] or NO [ ]

SECONDARY INSURANCE: _____

Contract #:_____ Group #: _____

Subscriber's Name: _____ DOB: _____ SS#: _____

Subscriber's Relationship to Client:_____ Subscriber's Employer: _____

Subscriber's Address if different than client's: _____

OFFICE USE:

Date Called: _____ Spoke with _____

Policy Year: Calendar/Renewal Month _____ COB? YES [ ] or NO [ ]

Deductible:_____ Deductible amount met: _____

Co-pay/ins:_____ Unlimited Visits: YES [ ] or NO [ ]

Authorization Required: YES [ ] or NO [ ]

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Credit/Debit/HSA/HRA Card Agreement

Lakeview Counseling, PC has implemented a policy which requires clients to pay for visits and copays at the time of service by cash, check or by choosing to use and maintain a valid Credit/Debit/HSA/HRA card on file with us. All applicable No-Show or late cancellation (less than 24 hours) fees of $50.00 will be charged to this card unless specified otherwise.

By providing us with your card information, you are consenting to Lakeview Counseling, PC to automatically charge the card on file for you, or any other client(s) listed below at the time of service or following a missed/late cancellation appointment.

Card Information

Credit ◯ / Debit ◯ / HSA ◯ / HRA ◯
***Please indicate type of card**

Card Holder's Name: _____

Card Number: _____ Exp. Date: _____

CVV code: _____ (3-digit code on back)

I authorize the above card to be used for the following individuals:

Name: _____

Name: _____

Name: _____

Name: _____

☐ **I agree to the use of the card on file to be charged for all fee's acquired with my services at Lakeview Counseling, PC**.

Card Holder's Signature: _____ Date: _____

You Can Pay Your Balance Using Visa, Mastercard or Discover

Three Simple Steps:

(1) Log onto professionalcharges.com.

(2) Select the "Make a Payment" button.

(3) Complete the Payment Form. You will need to enter the Tax I.D. number for Lakeview Counseling, PC — 383269851

Charges will appear on your credit card statement as "ProfessionalCharges.com".

If you have any questions, please contact us.

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Telehealth Informed Consent

I, _____, hereby consent to participate in telehealth communications with _____, as part of my psychotherapy. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media orother electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telehealth:

1. I understand that I have the right to withdraw consent at any time without affecting my right tofuture care or services.
2. I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where thedisclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information(PHI) also apply to telehealth services unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotionalhealth as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care may be required.
6. I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call (231) 929-0300 to discuss, since we may have to re-schedule.
7. I understand that my therapist may need to contact my emergency contact and/orappropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact onyour behalf in a life- threatening emergency only. This person will only be contacted to go to yourlocation or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone is: _____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date

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