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.

Therapist you're seeing:

Client Registration (Minor)

LEGAL NAME: _____ Today's Date: _____

Date of Birth: _____ Age: _____

The minor identifies their gender as: _____ Pronouns? _____

The minor's gender assigned at birth: ☐ Male ☐ Female

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 [☐]

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	[ ] ADD//ADHD	[ ] 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: _____

333 West Grandview Parkway, Suite 403, Traverse City, MI 49684
(231) 929-0300 | Fax (231) 933-6378

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

333 West Grandview Parkway, Suite 403, Traverse City, MI 49684
(231) 929-0300 | Fax (231) 933-6378

☐ 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

333 West Grandview Parkway, Suite 403, Traverse City, MI 49684
(231) 929-0300 | Fax (231) 933-6378

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

333 West Grandview Parkway, Suite 403, Traverse City, MI 49684
(231) 929-0300 | Fax (231) 933-6378

☐ 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: _____

333 West Grandview Parkway, Suite 403, Traverse City, MI 49684
(231) 929-0300 | Fax (231) 933-6378

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** _____