A New Day Counseling

LAURA L. RYAN, MA, LMFT

Please PRINT CLEARLY and fill out the form COMPLETELY

Client
Full Name_____ Date of Birth_____

Sex: F M Age: _____ Relationship Status: ☐Single ☐Married ☐Divorced ☐Committed Partnership ☐Widowed

Occupation _____

Home phone_____ Work phone _____ Cell phone_____

Email Address: _____

I authorize Laura L. Ryan to leave a message regarding my schedule:

☐ on my home phone ☐ w/ family member_____ ☐ at work ☐ on my cell phone

Payment of Services to A New Day Counseling

The person signing this agreement will be the responsible party for payment of services. Please provide their address and printed name, and indicate the relationship to the client--write "self" if you are the client.

I understand that I am responsible for any balance on the account and/or collection costs and legal fees incurred in any attempt to collect said balance.

AUTHORIZED PERSON'S SIGNATURE

Signed_____ Date_____

Printed Full Name_____ Relationship to client _____

Address:_____

City:_____State_____Zip_____

PHYSICIAN:
Name of Primary Care Physician _____

Phone # _____

Address_____

City/State/Zip_____

May we share information with your Physician? ☐ YES ☐ NO _____
Your Signature

REFERRAL SOURCE
How did you learn of my practice?

☐ yelp.com
☐ yahoo local
☐ google
☐ psychology today
☐ yellowpages.com
☐ doctor referral _____
☐ friend/family referral _____
☐ attended a workshop
☐ facebook
☐ other (please specify) _____

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LAURA L. RYAN, MA, LMFT

This form is provided in order you help you understand several important things about your professional relationship with your therapist and your rights as a client. Please read all of the information carefully. Feel free to ask questions about any item that you may not understand and sign the bottom of this form when you have read all the information.

Confidentiality

What you say to your therapist will be held in strictest confidence. However, you should understand that there are certain circumstances and conditions under which the content of your sessions may no longer be confidential. Below is a list of some, but not all of the circumstances under which your therapist may be ethically and/or legally obligated to disclose information about you. Because circumstances vary from individual to individual, it is impossible to provide a complete list of all possible circumstances under which the content of your sessions may no longer be confidential. Please discuss any concerns you may have about confidentiality with your therapist.

a) Your therapist is ethically and legally obligated to disclose information given in confidence if there is reason to believe that you may harm yourself or harm someone else.
b) Your therapist is ethically and legally obligated to disclose information given in confidence if there is reason to believe that you are involved in or have knowledge of child abuse/neglect or abuse/neglect of an elderly or disabled person.

Despite the personal nature of the work that you and your therapist do together, it is important for you to understand that you and your therapist have a *professional* and not a *personal* relationship. In order for your therapist to maintain his or her professional objectivity, the interactions between you and she will be limited to scheduled sessions. All clinical content should be discussed in session only and any text or email exchanges with your therapist will be limited to administrative, payment, or scheduling related inquiries. If you are in crisis, you agree to call 911 or report to your local emergency room. Please do not invite your therapist to social gatherings, offer gifts, or ask your therapist to enter into a business relationship or relate to you in any way outside of your scheduled appointments. You will be best served if your relationship with your therapist remains strictly professional and concentrates exclusively on your concerns. If you meet your therapist in public or in a social situation, be aware of her ethical responsibilities and expect a short conversation.

As a client, you have some important responsibilities. Please attend all scheduled appointments and be on time. Please remember that once an appointment is made, your therapist has set time aside for you and it is your responsibility to cancel/reschedule your appointments within 24 hours of your scheduled time. If you fail to cancel or reschedule your appointment within 24 hours, you will be charged the full hourly fee.

I, the client, have read and fully understand the information covered in this form.

_____ _____

Client Signature Today's Date

Tele-Therapy Consent to Treatment for Clients In Texas

I give consent to Laura L. Ryan, LMFT, license # 201931 A New Day Counseling Services to perform therapeutic services determined to be necessary or advisable for the benefit of my health. I understand that online counseling services include, but are not limited to, consultation and treatment using interactive audio, video, and/or data communications. I understand that online counseling services involve the communication of my medical/mental health information to the above referenced provider. By utilizing services with Laura L. Ryan, LMFT, I certify that I understand that communications via text, email, or any internet communication is not 100% HIPAA compliant and there is risk of breach of HIPAA in any form of electronic communication.

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. I understand that the laws that protect the confidentiality of my medical information also apply to online counseling services. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I understand that the dissemination of any information is under the same HIPAA standards as traditional therapy. Although rare, I understand that there are risks to internet based services including, not limited to, the possibility, despite reasonable efforts on the part of the Platform and/or Therapist, that the transmission of my medical information could be disrupted or distorted by technical failures, the transmission of my medical information could be interrupted by unauthorized persons, and/or the electronic storage of my medical information could be accessed by unauthorized persons.

I am aware that I agree that the location of the therapy is in Texas, where my licensed therapist is located, even when I am communicating with my therapist via digital or video platforms. I agree that my therapy is under the licensing rules and laws of the state of Texas. By participating in online therapy services I am aware of potential benefits and risks. Some benefits may include improved access to services and the convenience of not having to travel to my therapy appointments. Although risks are rare, I am aware there are possible risks which include the possibility of delay in response from my therapist due to technical failures or unforeseen events, and that I may not be able to respond to my therapist due to my own technology failures or unforeseen events. I am aware that all clinical content will be discussed during session only. I am not to text or email my therapist clinical content under any circumstance.

I understand that it is my responsibility to attend all scheduled tele-therapy appointments and be on time. I understand that once an appointment is made, my therapist has set time aside for me and it is my responsibility to cancel/reschedule your appointments within 24 hours of your scheduled time. If I fail to cancel or reschedule your appointment within 24 hours, I understand that I will be charged the full hourly fee. I understand that my therapist may not be able to provide certain services to me and if my therapist believes I need additional or other services, they may refer me to another specialist or type of care, such as seeing a medical doctor for further evaluation and treatment. Informed consent continues throughout the course of therapy and my therapist will continue to talk with me about risks, benefits or educate me on the process of therapy as we go along.

Signature_____ Date _____

LAURA L. RYAN, MA, LMFT

Name_____ Today's Date _____ DOB _____

General Behavior Assessment

1) How long have you suffered from your problem?
   a) 1-5 years
   b) 5-10 years
   c) 10-20 years
   d) As long as I can remember

2) Why have you failed to stop the behavior?
   (You may circle more than one)
   a) no willpower
   b) easily influenced
   c) fearful of change
   d) lack of self-worth
   e) depression
   f) other (please explain) _____

3) I think I need
   a) a very structured, regimented program
   b) a semi-structured program
   c) give me the basics and I can figure it out
   d) other (please describe) _____

4) The ideal amount of assistance you believe you need to work on this issue:
   a) very little involvement, I can do this on my own for the most part
   b) lots of assistance and attention, I often hit roadblocks and need support to get me back on track
   c) a moderate amount of assistance, I'm able to maintain my behaviors for the most part, but need some help from time to time when things get tough

5) To achieve good long-term outcome I need
   (You may circle more than one):
   a) someone to keep me responsible by checking up on me each week
   b) To learn how to become independent of external control
   c) I would like a minimum of involvement from others

6) Briefly describe a typical day in your life with special attention to where and when the behavior negatively affects your life. Please specifically describe the behavior(s) that you want to work on.

_____

_____

_____

_____

7) What situations are most likely to cause you to violate your plan – or what has caused you to go back to the negative behavior in the past?

_____

_____

8) What do you believe that you'll need to achieve a good long-term outcome?

_____

_____

9) Please describe what happened the last time you committed to working on/changing your behavior. How long did you stay involved with it?

_____

_____

10) In hindsight, what caused you to abandon the effort?

_____

_____

11) In what ways is this issue limiting you in your life?

_____

_____

How frequently do these thoughts pop into your mind?

Use this 5 point scale:

0 – Never, 1 - Rarely, 2 - Sometimes , 3 - Frequently, 4 - All the time

_____ I'm so weak

_____ I can't get started

_____ I wish I could have more respect for myself

_____ nothing feels good anymore

_____ I'm worthless

_____ there must be something wrong with me

_____ I can't finish anything

_____ I knew I could do it

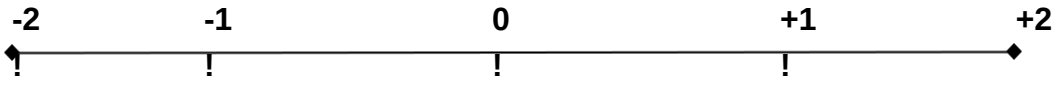
_____ I look forward to new challenges

_____ I take it as it comes

_____ I can handle the situation

For next questions rate your answers as: (*related to your problem behavior)*

Highly Improbable or Highly Probable



_____ I will carry through my responsibilities successfully

_____ No matter how hard I try, things just won't turn out the way I would like

_____ My motivation will decline over time and I will not stay the course

_____ I will become demoralized and abandon this effort

_____ I will do what it takes to achieve good long-term outcome.

12) What methods have failed to help you stop?

(You may circle more than one)

a. willpower
b. changing routines
c. psychotherapy
d. prescription drugs
e. group counseling
f. EMDR/hypnotherapy/EFT
g. other _____
h. all of the above

13) In what way has this behavior benefited you up to now?

(You may circle more than one)

a) gives me a sense of control
b) calming
c) relieves boredom
d) helps to distract me from worry
e) other _____
f) all of the above

13) What has made you decide to change your behavior?

_____

_____

_____

_____