DONNA VANDERKODDE, Licensed Professional Counselor COUPLE CLIENT PAPERWORK

Client 1 Name_____ DOB____/____/____ Age_____ Sex: M/F ___

❑ Minor, Guardian Name_____ Relationship to minor_____

❑ Unmarried ❑ Engaged, wedding date?____/____/____ ❑ Married, anniversary?____/____/____

❑ Separated, how long? _____ ❑ Divorced, how long? _____ ❑ Widowed, how long? _____

Address_____ City_____ State ____ Zip_____
Cell Phone (___)____-_____ Work Phone (___)____-_____ Other Phone:_____
E-mail _____ Occupation_____ Total hours/week _____
Employer_____ How long?_____

List the significant people in your life (good or bad influence) over the past two years (relatives, friends, etc.):

Name	Age	Relationship	Grade/Occupation	Living w/ you?	How long?
_____	____	_____	_____	Yes No	_____
_____	____	_____	_____	Yes No	_____
_____	____	_____	_____	Yes No	_____
_____					
_____	____	_____	_____	Yes No	_____
_____	____	_____	_____	Yes No	_____
_____	____	_____	_____	Yes No	_____
_____	____	_____	_____	Yes No	_____

EMERGENCY CONTACT, NOT LIVING AT YOUR HOME

Name (First/Last)_____ Relationship _____
Phone (___)____-_____ Email_____

INSURANCE INFORMATION

Primary Insured Name _____ DOB _____
Insurance Company _____
Group Policy Number_____ ID#_____
Insurance Customer Service Phone Number _____
Secondary Insured Name _____ DOB _____
Insurance Company _____
Group Policy Number_____ ID #_____
Insurance Customer Service Phone Number _____

HOW DID YOU FIND OUT ABOUT DONNA VANDERKODDE, LPC?

❑ Donna VanderKodde website ❑ A friend/relative _____

❑ linkedin website _____ ❑ Psychology Today website ❑ Gottman Institute website

❑ Insurance website, which one? _____ ❑ Focus on the Family website _____

❑ Other _____

Initial if you, the client (or guardian of the client), understand and agree to the information on this page. Client's initials: _____

PERSONAL BACKGROUND

Education _____ Military _____
Hobbies, Skills, Interests _____
Spiritual or Religious beliefs_____
How were these beliefs practiced in childhood_____
How are these beliefs practiced now_____

BRIEFLY EXPLAIN WHY YOU ARE SEEKING COUNSELING AT THIS POINT

_____
_____
When did this start occuring in your life_____
How much is this interfering with your life_____
What do you think it will take to resolve this problem_____
_____
What motivates you in your life_____
Have you ever experienced counseling in the past? Yes No Did it help resolve anything for you? Yes No\
Counselor name:_____ When? _____
Reason(s) for attending?_____
What was the experience like?_____

MEDICAL INFORMATION

Name of doctor:_____ Any ongoing or recent treatments? Yes No
What medications are you (or should you be) taking?_____
_____
Other specialist(s) you see and for what?_____

CREDIT CARD AUTHORIZATION

At Begin Anew Counseling, we keep your credit or debit card on file as a convenient method of payment for the portion of services that insurance doesn't cover, but for which you are liable, including charges for late cancellation or no show fees. Without this authorization, a billing fee of $5 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Furthermore, an "outstanding balance" charge of 20% of the total bill will be charged for each month that the bill remains unpaid. Your credit card information is kept confidential and secure. Payments to your card will be processed before the claim will been filed and processed by your insurer. I authorize Donna VanderKodde, LPC to charge the portion of my bill that is my financial responsibility to the following credit or debit card: ☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card #_____ Expiration Date _____/_____/_____ CCV Code _____
Cardholder Name _____
Email Address _____
Billing Address _____
City _____ State _____ Zip _____
Client's Name (Print): _____
Client (Signature):_____ Date: _____

Initial if you, the client (or guardian of the client), understand and agree to the information on this page. Client's initials: _____

SYMPTOM CHECKLIST (please check all that apply)

❑ I am quite satisfied with my life but would like to improve some things ❑ I am dissatisfied with my life and want a change ❑ I am dissatisfied with the current state of my family life ❑ I am dissatisfied in my relationship with my spouse or significant other ❑ I am dissatisfied with, confused about, or have questions regarding the sexual part of my life ❑ I am dissatisfied with my interpersonal relationships in general ❑ I am dissatisfied with my body ❑ In the past few months I have thought about how I could end my life

I have recently experienced: ❑ moodiness ❑ resentment ❑ stomach trouble ❑ anxious feelings ❑ racing thoughts ❑ unusual fatigue ❑ inability to relax ❑ bowel disturbances ❑ unusual anger or irritability ❑ mental confusion/disorientation ❑ decreased energy or motivation ❑ feelings of sadness, loss or grief ❑ apathy/hopelessness ❑ feelings of helplessness ❑ change in sex drive ❑ change of appetite ❑ inferiority feelings ❑ difficulty sleeping ❑ loneliness ❑ nightmares

In the last few months in order to try to feel better about my life, I have done the following: ❑ binge eating ❑ worked more than usual ❑ used illegal drugs ❑ drank alcohol ❑ isolated myself from people ❑ ignored my normal responsibilities ❑ refused to get out of bed or do normal hygiene ❑ used pornography or erotic material ❑ acted sexually in an unusual way for me ❑ misused prescribed drugs ❑ constantly surrounded myself with people ❑ harmed myself by cutting, burning, etc.

In my lifetime I have experienced: ❑ the loss of a loved one ❑ an abortion ❑ a miscarriage ❑ a traumatic event ❑ the death of a child ❑ divorce of my parents ❑ divorce of my own ❑ being fired from a job ❑ an addictive habit ❑ mental or verbal abuse ❑ physical abuse/assault ❑ sexual abuse/assault ❑ the loss of someone by suicide ❑ living with someone who was/is addicted ❑ something else significant to me

_____

_____❑ abandonment by important people to me ❑ being unloved by important people to me

WELCOME

Initial if you, the client (or guardian of the client), understand and agree to the information on this page. Client's initials: _____

Welcome to my private practice and thank you for choosing to work with me. My role as a therapist is to help you recognize your needs and wants, and to offer you support during the process of healing and growth. My therapeutic philosophy is a strength-based approach that is based on my belief that you are the expert of your life. We will work together to discover the best way for you to find answers to your problems. I am a Christian, and generally I counsel from a Christian perspective, but I will respect the wishes of each client who comes in my door whether you would like me to work from a Christian worldview or simply a neutral psychological perspective. Regardless, I look forward to our work together.

Client 2 Name_____ DOB____/____/____ Age_____ Sex: M/F ___

❑ Minor, Guardian Name_____ Relationship to minor_____

❑ Unmarried ❑ Engaged, wedding date?____/____/____ ❑ Married, anniversary?____/____/____

❑ Separated, how long? _____ ❑ Divorced, how long? _____ ❑ Widowed, how long? _____

Address_____ City_____ State ____ Zip_____
Cell Phone (___)____-_____ Work Phone (___)____-_____ Other Phone:_____
E-mail _____ Occupation_____ Total hours/week _____
Employer_____ How long?_____

List the significant people in your life (good or bad influence) over the past two years (relatives, friends, etc.):

Name	Age	Relationship	Grade/Occupation	Living w/ you?	How long?
_____	____	_____	_____	Yes No	_____
_____	____	_____	_____	Yes No	_____
_____	____	_____	_____	Yes No	_____
_____	____	_____	_____	Yes No	_____
_____	____	_____	_____	Yes No	_____
_____	____	_____	_____	Yes No	_____
_____	____	_____	_____	Yes No	_____

EMERGENCY CONTACT, NOT LIVING AT YOUR HOME

Name (First/Last)_____ Relationship _____
Phone (___)____-_____ Email_____

INSURANCE INFORMATION

Primary Insured Name _____ DOB _____
Insurance Company _____
Group Policy Number_____ ID#_____
Insurance Customer Service Phone Number _____
Secondary Insured Name _____ DOB _____

Initial if you, the client (or guardian of the client), understand and agree to the information on this page. Client's initials: _____

Insurance Company _____
Group Policy Number_____ ID #_____
Insurance Customer Service Phone Number _____

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Spiritual or Religious beliefs_____
How were these beliefs practiced in childhood_____
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BRIEFLY EXPLAIN WHY YOU ARE SEEKING COUNSELING AT THIS POINT

_____
_____
When did this start occuring in your life_____
How much is this interfering with your life_____
What do you think it will take to resolve this problem_____
_____
What motivates you in your life_____
Have you experienced counseling in the past? ❑ Yes ❑ No Did it help resolve anything for you? ❑ Yes ❑ No
Counselor name:_____ When? _____
Reason(s) for attending_____
What was the experience like?_____

MEDICAL INFORMATION

Name of doctor:_____ Ongoing or recent treatments? ❑ Yes ❑ No
What medications are you (or should you be) taking?_____
_____
Other specialist(s) you see and for what?_____

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Credit Card #_____ Expiration Date _____/_____/_____ CCV Code _____
Cardholder Name _____
Email Address _____
Billing Address _____
City _____ State _____ Zip _____
Client's Name (Print): _____
Client (Signature): _____ Date: _____

SYMPTOM CHECKLIST (please check all that apply)

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In my lifetime I have experienced: ❑ the loss of a loved one ❑ an abortion ❑ a miscarriage ❑ a traumatic event ❑ the death of a child ❑ divorce of my parents ❑ divorce of my own ❑ being fired from a job ❑ an addictive habit ❑ mental or verbal abuse ❑ physical abuse/assault ❑ sexual abuse/assault ❑ the loss of someone by suicide ❑ living with someone who was/is addicted ❑ something else significant to me

_____

_____❑ abandonment by important people to me ❑ being unloved by important people to me

WELCOME

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CREDENTIALS AND SERVICES

In my private practice I provide services to individuals, couples, and families. Sessions involve an eclectic counseling approach best suited to the individual including the Gottman method, cognitive, choice, existential, behavioral and family systems theories. Clients are evaluated and assessed and a collaborative counseling plan is developed based on the client's individual needs and desires. My education/experience includes the following areas: adjustment issues, adoption, anger, anxiety, assertiveness, childhood issues, Christianity, communication skills, conflicts, couples, death/dying, depression, grief/loss, infertility, life transitions, marital/premarital, miscarriage, self-esteem, and stress. I have met the requirements set by the Michigan Board of Counseling for Licensed Professional Counselors (LPC). I hold a Bachelor of Science degree in Bible & Theology as well as Interdisciplinary Studies from Kuyper College and I earned a Master of Arts degree in Counseling from Grand Rapids Theological Seminary (Cornerstone University).

AREAS OF SPECIALITIES

Building a trusting relationship with clients is the first step toward healthy successful counseling. My specialties are in marital therapy (including pre-engagement, pre-marital, and affair-recovery counseling), as well as working with persons dealing with pre and post adoption issues, infertility, and loss through miscarriage. My extensive training also allows me to work with a wide variety of client issues including children, teens, and adults struggling with anxiety, depression, stress, trauma, and a number of other situations due to unhealthy relationships, environments, and internal conflicts. My passion is helping marriages thrive. I guide couples through a process of repentance, reconciliation, restoration and finally toward renewed commitment to their

spouse. For those couples who have not yet said "I do", I provide pre-engagement and pre-marital counseling to help strengthen the marriage before it starts. In addiction counseling, I help men and women find stability and support by examining past relationships and environments and building new healthy trusting relationships with an emphasis on personal responsibility and accountability. To learn more about my counseling services, please visit my website: www.koddecounselingllc.com.

CONFIDENTIALITY AND INFORMED CONSENT

The therapeutic relationship requires complete confidentiality between client and therapist. Information about clients, including case notes and records are confidential and are the property of Donna VanderKodde LPC. In the event of my being unable to perform professional services, i.e., death or extreme disability, one of my colleagues, Josh Warren LPC, will safeguard your file according to state and national ethics rules and regulations.

The State of Michigan has established the following limits of confidentiality. You should be aware of these exceptions to confidentiality:

1. You provide consent to release your records or to share information regarding your treatment;
2. You are at risk of imminent serious harm to yourself or others*;
3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;
4. You disclose sexual misconduct of a physician or therapist;

5. Information is requested by your insurance company pertinent to processing claims for payment;
6. A court order is received to disclose information (e.g. child custody or mental competency cases);
7. You file a complaint with a licensing board or in cases of a malpractice suit, records will be released to the Board and/or legal counsel. *In the event that you are deemed an imminent danger to yourself or others, your therapist has a professional duty to contact the proper authorities. Medical and/or law enforcement officials may be notified with or without your consent. By signing below, you are stating that you have read and understood the rules of confidentiality.

_____ Signature of Client (or Guardian) Date _____

COUNSELING WITH MINORS AGE 14+

According to the Michigan Mental Health Code, MCL 330.1707, a minor 14 years of age or older, may request up to 12 sessions or four months of outpatient counseling without the consent or knowledge of the minor's parent, guardian, or person in loco parentis. The minor's parent, guardian, or person in loco parentis shall not be informed of the services without the consent of the minor unless the mental health professional treating the minor determines that there is a compelling need for disclosure based on a substantial probability of harm to the minor or to another individual, and if the minor is notified of the mental health professional's intent to inform the minor's parent, guardian, or person in loco parentis.

PATIENT PRIVACY NOTICE (HIPAA)

You may have the right to have us amend your protected health information. This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases,

we may deny your request for an amendment.

HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians/clinicians who may be involved in your care and treatment. We may use or disclose your protected health information, as necessary, e.g., to contact you to remind you of your appointment.

For Payment - Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a\ relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law - We may use or disclose your protected health information to the extent that the law requires the use or disclosure.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, file disclosure will be made consistent with the requirements of applicable federal and state laws.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule. By signing below, you confirm that you have read the above information regarding your Private Healthcare Information.

_____ Signature of Client (or Guardian) Date _____

SCHEDULING APPOINTMENTS

To schedule an appointment, simply go to www.koddecounselingllc.com. Click “Book Now/Pay Now”, choose the type of session, the date, and the time that best works for you. If you want to schedule a single session, choose "Continue". If you'd like to schedule multiple sessions, choose "Recurring". After you have scheduled your first session online please "register for an account" (an email address and password are required) to make scheduling and keeping track of your appointments as easy as possible and to reschedule or cancel any appointments. Donna VanderKodde LPC is a HIPAA covered entity and Acuity Scheduling is a HIPAA compliant service. Together they will make every effort to secure your protected health information.
NOTE: Only those who have a registered account can reschedule or cancel sessions they have booked online. Acuity Scheduling cannot and will not use your email for any other purposes beyond scheduling appointments with Donna VanderKodde LPC. Donna VanderKodde LPC does not keep your login information. If you do not desire to use online scheduling at this time, please call Donna VanderKodde LPC (616) 236-3281 to schedule your session over the phone. NOTE: If you need to set up an emergency session, please call Donna VanderKodde LPC directly (616) 236-3281.

RESCHEDULING OR CANCELING AN APPOINTMENT

Initial if you, the client (or guardian of the client), understand and agree to the information on this page. Client’s initials: _____

To reschedule or cancel an appointment, log in to your registered account at www.koddecounselingllc.com (see above) at least 24 hours before the session to avoid a $50 late cancellation fee. If you are unable to reschedule or cancel online, call or text Donna VanderKodde LPC directly (616) 236-3281.

CANCELLATION POLICY

You may can cancel or reschedule an appointment anytime, as long as you provide 24 hour advanced notice. If you cancel an appointment with less than 24 hours notice, or fail to show up, your credit card on file will be charged $50. I reserve for you, and all my clients, a full hour of my time for the session and clinical notes. If you cancel with less than a full 24-hour notice, I, more than likely, won't be able to fill that time slot, and I'll lose an entire hour from my work schedule. I want you to know that my cancellation policy is not a penalty. You may forget an appointment, have to work late, or have something come up that results in missing an appointment. You may get the flu, your kids will need to see the doctor, your car may break down, or something unavoidable may come up. I'm not upset with clients when they miss an appointment - life happens. Regardless of any of the above circumstances, a $50 charge will be administered to the card on file if you cancel an appointment with less than a 24 hour notice or fail to show up for your session. To cancel an appointment, log in on the "Book Now/Pay Now" page at www.koddecounselingllc.com, e-mail me at donna@koddecounselingllc.com or call/text me at 616-236-3281. If I am unavailable to take your call, you may leave a message at any time day or night, weekends or holidays.

**Note: The only rare exception to this policy would be if a severe weather related storm is in the area (extreme ice/snow storm, tornado warning, etc.).

**Note: If you are using insurance benefits to pay for sessions, insurance companies do not reimburse for missed appointments (less than 24 hr notice or failure to show). Therefore, if a client is using insurance for services, the fee for a missed appointment without 24 hour notice is also $50.

APPOINTMENT REMINDERS

In addition to scheduling appointments online, generic automatic appointment reminders, via text and email, are sent 48 hours and 3 hours before the scheduled session. Clients can choose to opt out from receiving reminders by clicking "unsubscribe" at the bottom of the appointment reminder email or by replying "STOP" to the appointment reminder text.

INSURANCE

Currently, I accept the following in-network insurances: Aetna, Blue Care Network, Blue Cross Blue Shield, Cofinity, Meridian, and Priority Health. I also can accept most out of network insurances but need full payment for services ($110) at the time of the appointment. I then provide a receipt of service that the client is responsible to send to their insurance company for possible reimbursement. To check if your insurance company covers therapy with Donna VanderKodde LPC, please complete the "Insurance Verification Form" at www.koddecounselingllc.com.

NOTE: Marriage and couples counseling is often not covered by insurance because it is not considered "medically necessary." If, however, one person has a diagnosable problem (depression, anxiety, adjustment, etc.) and it is increased by the marital problems, insurance may cover counseling that approaches the problem from the marriage standpoint. While this is a subtle issue, the question often becomes "Who is the client?" In

true marriage counseling, the "client" tends to be the relationship. If there are further questions regarding this topic, please contact Donna VanderKodde LPC for a more detailed discussion.

FEE CHART

In-Network Insurance (see below	Varies per copay/coinsurance / 55 minutes
Out-of-Network Insurance (might be reimbursable)	$110 / 55 minutes
Cash or check (not using insurance)	$110 / 55 minutes
Cash or check (not using insurance)	$160 / 85 minutes
Canceled/Missed Session without 24 hour notice	$50 fee
Phone calls (over 15 minutes)	$25 for every 15 minutes
Emails	$25 for every 15 minutes to read/respond

Court Action Fees See "Court Action Policy and Fees section

NOTE: There is a $25.00 return check fee

" Upon request, I also have a limited amount of sliding scale spots available based on need and necessity. Please contact Donna VanderKodde LPC to inquire about sliding scale details and availability.

PAYMENT

I accept cash, check, and most major credit cards for payment. You are responsible for the payment of your fees at the time of service. If payment is not completed on the date of service, the client can pay by credit card within one week after the appointment online at www.koddecounselingllc.com by clicking on the "Book Now/ Pay Now" tab. If the full session payment has not come within a week after the appointment, a $15 late fee will be assessed along with the session fee being charged to the credit card on file. Note: If you are more than 15 minutes late for an appointment, Donna VanderKodde LPC retains the right to cancel or reschedule your appointment, and a missed appointment fee may be assessed.

COURT ACTION POLICY AND FEES

Clients are discouraged from having Donna VanderKodde LPC subpoenaed or having her provide records for the purpose of litigation. I am trained as a professional therapist and my work and therapeutic philosophy comes from a non-adversarial position. I have not been trained forensically or with the expertise to appear in court. I am unable to guarantee that any testimony that I am required by law to give will be solely in your favor. I can only testify to the facts of the case and my professional opinion. If Donna VanderKodde LPC is to receive a subpoena, then the attorney or office staff will need to call my office and set up a time for the subpoena to be served during office hours. I request a minimum of 72 hours notice of any court appearance so that schedule changes for my clients can be made within a reasonable time frame. Please note: if a subpoena is received without a minimum of 72 hour notice there will be an additional $250 express charge.

Court action fees are as follows:

1. Preparation Time: $125 per hour (billable in 15-minute increments)
2. Phone Calls: $125 per hour (billable in 15-minute increments)
3. Emails: $25 for every 15 minutes to read and respond

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4. Filing Document with court: $100
5. Minimum charge for court appearance: $1,000 for half day $2,500 for full day
6. Attorney fees: The client agrees to pay all attorney fees and costs incurred by Donna VanderKodde as a result of any court action.
7. Retainer: A retainer of $1,000 is due at least 72 hours before the scheduled appearance.
8. The remainder of the costs will be billed after the court appearance and will be due upon receipt.
9. If a therapist is subpoenaed and the case is reset with less than 72 hour notice prior to the beginning of the day of the scheduled subpoena and/or testimony is not given then the client will be billed $1,000.
10. Bills for court related actions are presented to clients on a weekly basis and payment is expected upon receipt. A zero balance will need to be kept at all times.

_____Signature of Client (or Guardian) Date _____

OTHER IMPORTANT INFORMATION ABOUT MY PRACTICE

Office Hours

My office hours vary, but I'm generally in the office at least 4 days and 2 nights each week.

Therapist/Client Communication

If you need to call and leave me a message, you are welcome to do so. Generally during the week, I am either in session with clients or attending to my self-care and may not be able to answer my phone. However, I do check my messages and work hard to return calls as promptly as possible. If you need to talk with me about therapeutic or clinical matters between sessions, you may call for a brief, emergency consultation. These usually last about 10 minutes or less and are normally free. Calls lasting longer than 15 minutes or if you leave more than 15 minutes worth of phone messages in a week, you will be charged on a prorated basis for that time. For brief matters, such as requesting or rescheduling an appointment, you may email or text me. I generally check emails and texts during normal work days and do not always check email over the weekend. Please note, however, if I spend more than 15 minutes reading and responding to emails from you, you may be charged on a prorated basis. Email is not intended for emergencies or other urgent or time-sensitive matters. Email is also not intended for therapeutic or clinical material, and I ask that you refrain from including sensitive, confidential, or private information in any email communications with me as email can be easily accessed by unauthorized people, which can compromise the privacy and confidentiality of such communication.

Emergency Calls

If there is an emergency, call me at 616-236-3281. If there is an extreme life threatening emergency, call **911** or go to the emergency room of the nearest hospital. The following numbers may also be helpful:

- **Crisis Hotline: 1-800-231-1127**
- **Suicide Hotline: 616-336-3535**

Responsibility for Treatment

As with any other procedure, psychotherapy involves some risks. Whenever you make significant changes in your lifestyle, outlook or habits, your life and the lives of those with whom you are closely involved will be

affected. While the purpose of psychotherapy is to make changes, you will want to consider the consequences that might arise. Whatever changes you make will be both your choice and your responsibility. If you become concerned about the course of your therapy, please let me know so that you can have the course of treatment best for you. Complaints and Grievances I make every effort to provide services that are pleasing to you. If you believe I have failed to provide satisfactory care or have acted unprofessionally or unethically, please let me know, so I am able to correct this. To file a grievance with my licensing boards, you may write to: Michigan Department of Licensing and Regulatory Affairs, Health Professions Division Enforcement Section, P.O. Box 30670 Lansing, MI 48909 or fax (517) 241-2635.

AGREEMENT

I have read the above and accept the foregoing policies. A copy of this form is as valid as the original. I certify that I am over fourteen years of age and consent to the above conditions for therapy.

_____Printed Name of Client Date _____

_____Signature of Client Date _____

_____ Parent/Guardian/Legal rep.(signature for minor) Date _____

Initial if you, the client (or guardian of the client), understand and agree to the information on this page. Client's initials: _____

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