MELISSA PRESTON
COUNSELING

Client Therapist Agreement

Lexie Garfield-Turner, MSW, LSW
lexiedgt@gmail.com
(248) 376-2726

Welcome!
This form will answer most of your questions about therapy services at my office. Please feel free to ask additional questions to clarify anything at your initial session.

Degrees and Credentials:

Bachelor of Psychology, Michigan State University, December 2013
Master of Social Work, University of Michigan, April 2016

Licensed Social Worker: 0009921657

Regulatory requirements applicable to LSW and LCSW: A Licensed Clinical Social Worker (LCSW) must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Social Worker (LSW) must hold a masters degree in social work.

What is therapy and how does it work? Therapy is a collaborative process between myself, the counselor, and you, the client, and works on solving emotional problems so that you may live a more fulfilling and happier life. The process of change is often difficult and may exacerbate your symptoms initially, however, over time you should see an improvement. The most important factor for success in therapy is good communication between you and me. If at any time, you feel your needs are not being met, I invite you to express these concerns so they can be worked through.

Clients Rights and Limitations of Service

1. You are entitled to information from me about my approach to therapy, techniques, and the duration of therapy
2. You can seek a second opinion from another therapist or terminate therapy at any time.
3. My fee is $130 per 50 minute session of therapy. My fee is $195 per 75 minutes of therapy. Payment must be made at the time of service in the form of cash, check, or credit card. I do not accept insurance for services rendered. If you would like to submit a bill to your insurance company for reimbursement I will provide you with a form at the end of each month. Please inform me if you would like this form. Checks need to be made out to

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Melissa Preston Counseling. There is no charge for brief phone conversations between sessions or for emails. Any phone conversation extending beyond 10 minutes will be billed according to the pro-rated hourly fee.

4. **PLEASE NOTE: Clients may choose to email, text or utilize social media to contact their therapist. These modes of communication, while protected with passwords specifically chosen by the therapist, cannot be guaranteed as confidential forms of communication
5. In a professional relationship, sexual intimacy is never appropriate and is illegal in the state of Colorado. If sexual intimacy occurs, it should be reported to the State Grievance board.
6. By law and professional ethics, our sessions are strictly confidential. Generally no information will be shared with anyone without your consent and release of information. There are however a number of exceptions to this rule:

a. Supervision and consultation with a colleague when I feel this is necessary for guidance regarding any issues that come up in therapy.
b. I am required to report any suspected incident of child or elder abuse or neglect to law enforcement.
c. I am required to report any threat of imminent physical harm by a client to law enforcement and to the persons(s) threatened.
d. I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others.
e. I am ordered by the court to testify or release records
f. There is a release of information given by you, the client.
g. I am seeing a minor aged 15 or under and parents request information.

7. I provide non-emergency psychotherapeutic services by scheduled appointment. If I believe your psychotherapeutic issues are above my level of competence, or outside of my scope of practice, I am legally required to refer, terminate, or consult. If you are having a true emergency, you should call 911 or check yourself into the nearest hospital emergency room immediately if your personal safety or mental health is at stake.
8. Sometimes in psychotherapy things get worse (because of repressed issues and systematic dynamics) before things get better. By signing this, it states that you understand this may be a natural part of the psychotherapeutic process.

Regulation of Psychotherapists:
The practice of licensed social workers or licensed clinical social workers is regulated by the Mental Health Licensing Section of the Division of Registrations of the Colorado Department of Regulatory Agencies. The Board of Social Work

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Examiners can be reached at:1560 Broadway, Suite 1340, Denver, CO 80202, (303) 894-7760.

Cancellations: You will be charged for all cancelled appointments if not done within 48 hours (weekends and holidays excluded) of your appointment. You may leave a message on my voice mail (248-376-2726) or email me at lexidgt@gmail.com to cancel an appointment. All Monday appointments must be cancelled or rescheduled by the Thursday prior to the appointment.

Treatment Planning:
Periodically, client and therapist will assess progress toward treatment goals. It can be mutually beneficial if termination is discussed in advance. In the event that 60 days transpires since the last scheduled appointment, it will be assumed that treatment it terminated. A client may choose to re-engage in the therapy process at any time but must contact the therapist to re-establish treatment services.

I have read the preceding information and understand my rights as a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. By signing this disclosure statement, I also agree to permit consultation and I provide release for my psychotherapist(s) to seek consultation with the agency that referred me and/or my minor children, other psychotherapists or professionals as the need arises. I also affirm, by signing this form, that I am the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children for whom I am requesting psychotherapy services by Melissa Preston. This disclosure statement will be automatically revoked one year after signing in compliance with HIPAA guidelines.

I have received a copy of the NOTICE OF PRIVACY PRACTICES. _____Client Initials

_____	_____
Client Name (printed)	Parent/ Guardian (printed)
_____	_____
Signature	Signature
_____	_____
Date	Date

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Name_____ Name you would like me to call you _____

Employed: Yes/ No Length of Employment: _____
Occupation: _____
Religious affiliation: _____Sex: _____ Sexual Orientation_____
Height: _____ Weight: _____

Why are you (or your child) seeking treatment at this time?

_____
_____
_____
_____

Describe any current stressors in your (or your child's) life:

_____
_____
_____
_____

Have you had previous mental health treatment? Yes [] No[] If so, when, where, and for how long?

_____
_____
_____

What type of therapy did you have (*e.g. medication, counseling, dietary*)?

_____
_____

What has been helpful in previous outpatient treatment?

_____
_____

Have you ever been hospitalized for any psychiatric treatment (*e.g. substance abuse, eating disorder, etc*)? If so when, where, and why?_____

_____
_____

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Any family history of psychiatric illness (*including depression, bipolar, schizophrenia, drug or alcohol abuse, panic attacks, anxiety, OCD, eating disorders, etc*). Please list the problem and which relative had struggled.

_____
_____
_____

Social History (If Applicable):

Marital status: Single [] Married [] Separated [] Divorced [] Widow [] Life Partner []
Spouse name: _____ Spouse age: _____
If married, how long? _____ Spouse's occupation: _____
If separated/divorced, date?_____ number of years married? _____
Children (name and ages) _____
Who is currently living in your household (age and relationship)?_____
_____

Family Members:

Mother:
Name: _____ age_____ occupation_____ if deceased, your age at the time of her death _____ , her age_____
cause of death: _____

Father:
Name: _____ age_____ occupation_____ if deceased, your age at the time of his death _____ , his age_____
cause of death: _____

Siblings:
Names: _____
Ages: _____
How did/do you get along with him/her?
_____
_____
_____

Personal/Developmental History

Highest level of education_____
Area of Study: _____

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Any history of learning disorder Yes [] No[]
Any history of Gifted or accelerated learning Yes[] No[]

Have you ever served in the Military Yes[] No[]

Any history of trauma or abuse:

Sexual Yes[] No [] _____
_____
Physical Yes[] No[] _____
_____
Verbal/Emotional Yes[] No[] _____
_____

Substance Use/Abuse:

	Frequency	Amount	First use	Last use
Alcohol				
Marijuana				
Cocaine				
Amphetamines				
LSD				
Cigarettes				
Other				

Do you view your substance use as problematic? Yes / No

Any history of legal problems (*e.g. divorce, bankruptcy, theft, etc*)?
_____
_____

Medical History:

Any current medical problems? _____
_____

Describe any significant past illness? _____
_____

Current medications and doses? _____
_____

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Mood Assessment:

Do you feel Depressed? Yes / No
If so: What percentage of the day do you feel depressed? _____
What symptoms of depression do you feel you currently exhibit and how long have they been present? _____

Are simple tasks difficult for you to accomplish? Yes/ No
If so, are you able to complete them anyways? _____

Do you feel Anxious? Yes / No
What percentage of the day do you feel anxious? ____

Have you ever experienced a panic attack? Yes/ No
When was your most recent panic attack? _____

Any OCD symptoms? Yes / No If yes please explain
_____

Any PTSD symptoms? Yes / No If yes please explain
_____

Body Acceptance & Eating Disorder Related Assessment:

Do you find yourself feeling shame about your body? Yes / No
If yes, roughly what percentage of the day do you find yourself thinking about your body and wanting to change your body? _____

Do you actively or have you actively tried to change your body through extreme diet & exercise? Yes/No
If so, did you lose weight, change clothing sizes, etc.? If you lost weight how much did you lose? _____
_____

Do you find yourself thinking about your weight, shape, or size often? Yes/No
If so, what do you find yourself most consumed with? _____
_____

Do you find yourself comparing yourself to those on social media, celebrities, friends, family members, etc? Yes/ No

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Do you find yourself restricting your food intake for much of the day and binging for periods of time? Yes/No
If so, are these binges typically associated with sadness, anger, stress, anxiety, etc? Yes /No

Do you find yourself obsessively counting calories, logging your food intake, or monitoring which/how many macros you consume daily? Yes/ No

Have you been in treatment for a diagnosed eating disorder in the past or currently? Yes/No
If so, what was the diagnosis & where did you seek treatment?

_____
_____

Additional:

Has anything significant (any event, incident, or action that YOU perceived to be significant, positively or negatively, even if others aware of the event, incident or action did not think it was significant) happened in your life in the past 2 years? If so, what and how has it affected you?

_____
_____
_____
_____

Please add anything not covered in this questionnaire that you feel could help me understand your presenting struggle(s)?

_____
_____
_____
_____

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Credit Card Authorization Form

Please note that this form will be securely stored in your clinical file and that you are willing to assume the risk for keeping this information on file.

I authorize Lexie Garfield-Turner, MSW, LSW and Melissa Preston Counseling to keep my signature and card information on file and to charge therapy session fees (individual, groups, workshops, couples, family or other) at the end of such sessions if I prefer not to personally pay with cash, check, or card at that time. My signature and card information will also be used for appointments scheduled with Lexie Garfield-Turner, MSW, LSW that are not cancelled within 48 hours of the scheduled appointment time OR if I do not show up and do not call to cancel within 24 hours prior. In the event that you do not call ahead of time and do not show up to a scheduled appointment, the full fee of the session agreed upon by Lexie Garfield-Turner, MSW, LSW and you as the client will be charged. In any of the above scenarios such charges will be made to my credit, charge, debit card, or flex spending account as filled out below for therapy services provided to:

_____

(Therapy client's name: Please Print)

I understand that this authorization is valid until cancelled in writing. I understand that this form along with all other personal client forms will be kept in an individual, secure file and will not be used for any reasons not listed in the preceding paragraph. I understand that though this information is secured in my client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for on-going services will normally be posted to my credit/debit/flex card account within 72 hours of each session date and my session fee will be charged after the session is complete. Additionally, I agree that the card listed below may be charged by Lexie Garfield-Turner, MSW, LSW and Melissa Preston Counseling in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials (i.e. books, CDs DVDs, etc) that have not returned within one week of termination. I understand that if a charge back fee is incurred, I am responsible for that fee. **Initial**: _____

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Lexie Garfield-Turner, MSW, LSW, Melissa Preston Counseling for any assistance and/or disclosure, I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Lexie Garfield-Turner, MSW, LSW, Melissa Preston Counseling and those attempts have failed. **Initial**: _____

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself that is not a

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minor that I am the parent or legal guardian of, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by Lexie Garfield-Turner, MSW, LSW, Melissa Preston Counseling. **Initial**: _____

……

I understand and agree to these terms and the conditions of this payment policy and agree to the conditions stated above:

Signature: _____
Cardholder Name (Print): _____
Relationship to client: _____

Card Type (circle one): Visa Mastercard Discover American Express HSA

Card Number: _____ - _____ - _____ - _____
Expiration Date: _____ **Security Code (3 digit): _____**

Credit Card Billing Address: _____
_____

Telephone Number: _____

I understand that therapy sessions cancelled in less than 48 hours or appointments that I do not show up to with any prior notice will be charged via this form.

Cardholder Signature: _____
Date: _____