Kelly-Johnston Counseling, PLLC
When Healing Matters
KellyJohnstonCounseling.com
Jaye@KellyJohnstonCounseling.com

INFORMATION, AUTHORIZATION & CONSENT TO TREATMENT

This document is intended to inform you about what you can expect from your practitioner, policies regarding confidentiality and emergencies, and other details regarding your sessions. This document is part of an ethical obligation to our profession as well as our commitment to keep you informed of every part of your therapeutic experience. Your relationship with your practitioner is a collaborative one; thus, we welcome any questions, comments, or suggestions regarding your sessions at any time.

Jaye Kelly-Johnston, MA. LPC-S, CMS-CHT, FIBH, Licensed in the State of Texas as a Licensed Professional Counselor-Supervisor. NPI # 1881764702. Jaye received her master's degree from Sam Houston State University. She is a Fellow of the International Board of Hypnotherapy. She is a Nationally Certified Medical Support Hypnotherapist from The Hypnotherapy Academy of American and a member of the following

Professional Organizations:
Texas State Board of Examiners of Licensed Professional Counselors .License # 15145.
American Psychological Association.
American Counseling Association.
International Board of Hypnotherapy Certification number # F11017-514.

Professional Counseling by law the practice of professional counseling is defined as the application of mental health, psychotherapeutic principles to facilitate human development and adjustment throughout the life span. Conduct assessments and evaluations to establish treatment goals and objectives; and plan, implement, and evaluate treatment plans.

Hypnotherapy is an educational and self-improvement process that facilitates access to a person's internal resources to assist him/her in solving problems, increasing motivation, or altering behavior patterns to create positive change. Hypnotherapy is not a substitute for medical treatment. Kelly-Johnston Counseling, PLLC does not practice medicine.

Medical Support Hypnotherapy is used only as an adjunct to conventional medical treatment. Consultation with a licensed physician is required before medical support hypnotherapy services are provided.

In Order To Be More Successful in Reaching My Goals, I Agree To:

- Be an active participant in my psychotherapy and or hypnotherapy experience and see myself as a partner in the transformative nature of this process.
- Recognize that my thoughts, feelings, images and actions have a direct effect on the quality of my life.
- Acknowledge that my well-being depends directly on how well I care for myself physically, emotionally, intellectually and spiritually.
- Accept that blaming others or myself is totally futile.
- Take responsibility for my experience of life, because I create my life experiences to the best of my ability in the moment, with what I know right now.
- I agree to be on time for sessions and allow **at least 24 hours** of advance notice should I need to cancel or reschedule a session @ 281-536-6503.

□ **By checking this box, I acknowledge that I have read and received the Limitations on Confidentiality.**

□ **By checking this box, I acknowledge that I have read and received the Basic Rights for All Clients form.**

□ **By checking this box, I acknowledge that I have read and received the Fees and Financial Policies form**

□ **By checking this box, I consent for services to be provided by Kelly-Johnston Counseling, PLLC.**

_____ _____
Client / Parent / Guardian (Print) Date

_____ _____
Client / Parent / Guardian (Signature) Date

Complete HIPPA text available at www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/adminsimpregtext.pdf Provider credentials can be verified through the Texas State Board of Examiners of Professional Counselors. Complaints can be made by calling 1-800-942-5540 or contacting: Investigations, P.O. Box 141369, Austin, Texas 78714.

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Client Information Sheet

Client Name: _____

Parent Name for Minor:_____

Address: _____

City, State: _____Zip:_____

Phone Number: Home:_____ Cell:_____

Can Leave Message: ☐ Yes ☐ No

Email: _____

Can send emails: ☐ Yes ☐ No

Referral Source: _____

Date of Birth: ____/____/_____ Age: _____

Marital Status: Minor Single Married Divorce Separated Widowed

Military Service: ☐ Yes , branch:_____ ☐ No

Employer/School: _____

Education Level: _____ Religion: _____

Emergency Contact: _____ Phone: _____

Relationship to You: _____

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Medical and Mental Health History

Date of your most recent physical examination: _____

Please list all current mediations and dosages:

Current Medications	Dosage (mg)	Frequency	Physician's Name

Please list all current or past physical health problems:

Current	Past:

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Medical and Mental Health History page 2

Counseling / Hypnotherapy History

In the past, have you received inpatient or outpatient mental health treatment	_____Yes	____No
In the past, have you ever experienced a traumatic head injury?	_____Yes	____No
In the past, have you received individual or group hypnotherapy sessions?	_____ Yes	____No
In the past, have you ever been treated for drug and alcohol abuse/dependence	_____Yes	____No

If you answered yes to any of the previous questions, please explain:

_____

_____

What brought you to schedule services at this time?

_____

_____

What Other Information Would You Like to Share That You Believe Would Be Helpful

_____

_____

What are you expecting from sessions?

_____

_____

_____

_____

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Medical and Mental Health History page 3

Life Events: **Please check any and all life events that you have experienced over the last 12 months:**

☐ Death of a spouse	☐ Family member ill	☐ Foreclosed on mortgage	☐ Change of work hours
☐ Divorce	☐ Pregnancy of self/partner	☐ New work responsibilities	☐ New residence
☐ Marital separation	☐ Sexual difficulties	☐ Child leaving home	☐ Change of school
☐ Death of a close relative	☐ New addition to the family	☐ Trouble with in-laws	☐ Recreational change
☐ Personal injury or illness	☐ Change in finances	☐ Partner begins/stops work	☐ Church activity changed
☐ New marriage	☐ Death of a close friend	☐ Began/Finished school	☐ Social activities changed
☐ Fired from work	☐ New job	☐ Living conditions changed	☐ Change in sleep patterns
☐ Marital Problems	☐ Arguing with spouse	☐ Change of personal habits	☐ Change in eating habits

Presenting Symptoms

Please check any symptoms you have experienced over the last two weeks:

	None	Mild	Moderate	Severe
Suicidal Thoughts	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Feelings of Hopelessness	☐	☐	☐	☐
Feelings of Worthlessness	☐	☐	☐	☐
Difficulty Concentrating	☐	☐	☐	☐
Lost Interest in Activities	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐
Social Isolation	☐	☐	☐	☐
Sexual Dysfunction	☐	☐	☐	☐
Change in Sleep Pattern	☐	☐	☐	☐
Appetite Loss/ Gain	☐	☐	☐	☐
Weight Loss/ Gain	☐	☐	☐	☐

	None	Mild	Moderate	Severe
Homicidal Thoughts	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Obsessive Thoughts	☐	☐	☐	☐
Extreme Fears	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐
Elevated Mood	☐	☐	☐	☐
Racing Thoughts	☐	☐	☐	☐
Feelings of Guilt	☐	☐	☐	☐
Feeling Distracted	☐	☐	☐	☐
Anxious Thoughts	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐
Paranoia	☐	☐	☐	☐

On average, how many hours of sleep do you get each night? _____Hours

On average, how much weight have you lost/ gained (circle one) in the past few months? _____Lbs

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Medical and Mental Health History page 4

Family History of Mental Health and/or Substance Use: (X all that apply)

	Mother	Father	Siblings	Self	Age started	Frequency of usage
Alcoholism						
Amphetamines						
Cocaine						
Heroin/Opiates						
Marijuana						
Anxiety						
Depression/ Mood D/O						
Eating Disorder						
Schizophrenia						
Suicide Attempt						

Childhood History:

Briefly describe your mother as you remember her in childhood:
Briefly describe your father as you remember him in childhood:

Check all descriptors that accurately characterize your childhood experience:

☐Loving/Supportive	☐Unstable	☐Emotional Abuse	☐Molestation	☐Rejected By Father
☐Chaotic	☐Parents Argued	☐Verbal Abuse	☐Spiritual Abuse	☐Rejected By Mother
☐Stable	☐Physical Abuse	☐Sexual Abuse/ Rape	☐Witnessed Violence	☐Little Memory

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CREDIT CARD AUTHORIZATION FORM

All information will remain strictly confidential. Your credit card will be kept on file. Insurance companies require the copay at the time of service. Your credit card will be billed using a secure, HIPPA compliant software. "No-Shows" and cancellations under 24 hours will be billed for the session. Please review "No-Show" and "Cancellation" policies.

Client Name: _____

Cardholder Name: _____

Address _____City _____,State_____ Zip Code: _____

Credit Card Type: ___Visa, ___MasterCard, ____Discover, ___American Express

Card Number: _____

Expiration: _____ Security Code: (CVVS) _____

I authorize Kelly-Johnston Counseling, PLLC to charge the agreed amount to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Sign and Date Below:

Signature: _____ Date: _____

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Limitations on Confidentiality

All information regarding evaluation, diagnosis, observations, interactions, and treatment of a client is confidential information that this provider will disclose only to authorized people and agencies. The client and/or parent must provide prior written permission and authorization before any information will be released to another person, agency, or professional organization either verbally or in writing. Confidentiality and privacy of all client information will be maintained to the highest standards of the law and ethical practice.

The following are legally specified and required exceptions to the laws of confidentiality:

- If a counselor learns of child or elder abuse that is currently taking place or has the probability of recurring, he or she is legally required to report that abuse to the appropriate authorities.
- If a client discloses an intention to do something that is likely to harm him/herself or others, the counselor is required to report that intention to authorities.
- If a court order/subpoena, or other legal proceeding requires disclosure all records may be released.
- If the client enters into litigation against the therapist.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations implemented standards for how information that identifies a patient can be used and disclosed. (Title 45, Code of Federal Regulations (CFR), Parts 160 and 164) The regulations apply to “covered entities” including health-care plans, health-care clearinghouses, and health-care providers. These privacy standards went into effect on April 14, 2003.

In regards to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I have been made aware of how my medical information may be used and disclosed and how I can get access to this information.

I understand confidentiality and its limitations.

_____ _____
Client / Parent / Guardian (Print) Date

_____ _____
Client / Parent / Guardian (Signature) Date

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Basic Rights for All Clients

- You have the right to impartial access to treatment regardless of race, religion, gender, age, ethnicity, or disability.
- You have the right to considerate and respectful treatment and recognition of your personal dignity.
- You have the right to a written statement of your rights.
- You have the right to be informed of your rights in a language you understand.
- You have the right to adequate, appropriate, and compassionate services regardless of financial ability.
- You have the right to services provided in the least restrictive environment possible.
- You have the right to participate in all treatment decisions
- You have the right to obtain information about treatment recommendations and alternatives.
- You have the right to obtain information about your condition and prognosis from your clinician.
- You have the right to a periodic review and update of your treatment plan.
- You have the right to be involved in referral or termination of treatment.
- You may terminate services at any time unless legally prohibited from doing so.
- You have the right to be informed of clinical alternatives available when you leave treatment with specific follow up recommendations distinctively outlined.
- You have the right to report any incidents of abuse or neglect, whether you are a victim or an observer. You will be provided with these contact phone numbers and addresses before the initial session.
- You have the right to expect that all communications and records pertaining to your treatment be treated as confidential, except as otherwise required by law.
- You have the right to be told of any experimental treatment approach recommended for you, and you must give your written consent before any such approach can be used.
- Patients, significant others, and staff have the right to have ethical issues that arise in treatment considered, discussed and dealt with in a clinically appropriate manner.
- You and your family/significant others, have the right to request a review of the practices and procedures for insuring patient's rights and for addressing questions or complaints about your individual treatment plan. 19. You have the right to be told in advance of all estimated charges being made, the cost of services provided, sources of the clinic's reimbursement, and any limitations on length of services known.
- You have the right to withdraw your permission at any time in matters to which you have previously consented.
- You have the right to request the opinion of another clinician or psychiatrist at your own expense.

I certify that I have received a copy of this document prior to treatment and I was given the opportunity to ask questions regarding my rights as a client. I understand that ethical boundaries exist between therapist and client. Mutual respect is required for a successful therapeutic relationship. Any situation that violates or blurs these boundaries will be discussed and may lead to a termination of the therapeutic relationship. This includes excessive and/or disrespectful use of electronic and telephone communication. As always, feedback is invited and if at any point questions arise regarding professional boundaries, the client holds the right to question this professional relationship.

_____ _____

Client / Parent / Guardian (Print) Date

_____ _____

Client / Parent / Guardian (Signature) Date

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Fees & Financial Policies

We recognize that our services often involve a serious financial investment for most people. We also believe that these services are a crucial investment in more fully becoming the person you were created to be.

At Kelly-Johnston Counseling, PLLC, the first appointment is a 75-minute in length aimed at building a relationship with you, clarifying the nature of your struggles, and exploring how we might work together to assist you. Subsequent sessions are 45-75 minutes in length.

Psychotherapy Fees		**Hypnotherapy Fees**	
Initial appointment (75 minutes):	$150.00	Initial appointment (75 minutes):	$150.00
Subsequent sessions (45-75):	$150.00	Subsequent sessions (45-75):	$150.00
Children under age 12 (up to 45 mins)	$150.00	PLRT (up to 90 minutes)	$225.00
After-Hours Sessions:	$225.00 and up		

*After-Hours session fees apply to any appointment scheduled after 7:00pm or weekends and various holidays.

All fees are due at time of service. A charge of $75.00 will be charged for any checks that do not clear the bank. All counseling fees are subject to review and/or change.

Cancellations/No Shows
Since we regard time as a precious gift from God and our sessions with you as a joint commitment to our work; No Shows or appointments cancelled with less than 24 hours notice will be charged 100% of the fee of session. While all consultations are free, there will be a $50.00 charge for no-shows.

Insurance
Kelly-Johnston Counseling, PLLC does not participate in insurance plans or insurance panels. We believe that remaining outside of this system will help us to safeguard your privacy, enable us to focus more solely on providing the best services we can, and keep our administrative expenses down.

Self-Pay
We accept cash, checks, and credit cards at the time of service. PayPal for online payments for tele-video sessions. All tele-video sessions must be paid in advance of session.

Refund Policy:
From time to time, Kelly-Johnston Counseling, PLLC will offer discounted rates for multiple sessions purchased in advanced. You can always take advantage of such incentives, but please be aware, while sessions never expire and can be used any time, gifted or donated, that Kelly-Johnston Counseling, PLLC. does not offer refunds on unused sessions.

I consent to receive counseling/hypnotherapy sessions and agree to pay all fees in accordance with the terms set above..

_____ _____
Client / Parent / Guardian (signature) Date

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To Sum It Up

- Confidentiality is a priority. For any reports, notes or conversations outside the office, I will need your written approval.

- Every client will have a credit card on file. "No-Shows" and last minute cancelations will be billed the session fee.

    - I hate to do this but unfortunately, it's necessary.
    - You have my email and cell phone number for this purpose.

- You have all the rights afforded to you under law and common decency.
  If you want therapy to take a different direction, you are the boss and free to say so
  If needed, I will provide professional referrals to the best of my knowledge and ability.

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