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INFORMED CONSENT – ADULT

TRAINING AND BACKGROUND

Karen Peninger, M.Ed., LPC-Intern is a Licensed Professional Counselor-Intern licensed by the Texas State Board of Examiners of Professional Counselors under the supervision of Penny Haight, LPC-S

I have worked with individuals of all ages, ethnicity, gender, religion, sexual orientation, and socio-economic status. Karen Peninger, M.Ed., LPC-Intern under the supervision of Penny Haight, LPC-S is trained in multiple methodologies including Applied Behavior Analysis (ABA), Solution Focused Brief Therapy (SFBT), Cognitive Behavioral Therapy (CBT), Play Therapy, Art Therapy, and Sand Tray Therapy. I am also a Certified School Counselor and Certified Positive Discipline Parent Educator.

CONFIDENTIALITY AND HIPAA

I will treat all information you share with confidentiality according to HIPAA standards. It is your right that sessions and records be kept private. Texas state law requires to inform you that in certain cases your confidentiality is not protected, and your information may be disclosed to the appropriate authorities/agencies. These cases are:

- If there is reason to believe that you may harm yourself or others.
- If there is reason to believe that you are involved in or have knowledge of abuser neglect of a child; or abuse, neglect, or exploitation of a person who is elderly or has a disability.
- If I am ordered to disclose by state or federal courts.

The Texas State Board of Examiners for Licensed Professional Counselors requires to notify you who would maintain records in the case of my death or disability. Loretta Smith is the Custodian of Records and she has agreed to follow the guidelines set forth by the above-mentioned board. Additionally, you may sign a release form granting permission to designated third parties to receive and send information that you request. I will never disclose your information for any reason without your knowing of her intent.

_____ Initials

THERAPEUTIC RELATIONSHIP

The relationship between therapist and client is the container through which change can take place. As such, the relationship is often one in which close emotional bonds develop. It is also a professional relationship, in which appropriate boundaries must be maintained. Because the therapist client relationship is so important, I cannot be involved in a social relationship or friendship that exists

outside of the therapy room. Limiting the relationship to the office keeps your therapeutic environment safe, secure, and free of outside complications that could interfere with your therapy work. Counseling can improve as well as upset the equilibrium in any person or family. Counseling is a personal exploration and may lead to changes in your life perspectives and decisions. These changes could be temporarily distressing. You may leave a message on a private, confidential voice-mail (817-657-1115) at any time. However, this number is not an emergency phone number. I do not provide 24-hour crisis counseling. Should you experience an emergency necessitating immediate mental health attention call 9-1-1 or go to an emergency room for assistance.

_____ Initials

FEES

The fee is $150.00 per 50-55 minute session. Payment in full is due at the time services are rendered. Fees must be paid at the beginning of each session. When payments are collected at the end of a session, the momentum of the session can be de-railed.

Should I need to communicate with lawyers, communicate with insurance companies, complete documentation for medical needs, complete documentation for psychological evaluations, complete FMLA forms, complete ESA documentation, etc. **I charge a fee is $80 per half-hour.** Should you request for me to complete any documentation or attend any meetings without 48 hours' notice an additional expedited fee of $40 will be assessed. Should you subpoena me as a factual case witness or involve her in any court-related processes, **I charge a fee of $2,500.00 for legal depositions, case preparation, travel, and witness time**.

_____ Initials

SESSION GUIDELINES

Sessions are 50-55 minutes. Sessions begin on the hour and end at the scheduled time. Late arrival on your part will not extend the scheduled ending time for a session. The frequency of sessions and the length of the psychotherapy are aspects of the work that you and I will decide together. Brief therapy is usually around 10 sessions. Some clients need additional sessions to reach their treatment goals. If there is a set time and day that works best for your schedule (e.g., every Monday at 5 PM) a recurring appointment may be arranged if that time and day is available. However, after 2 cancellations that recurring spot will be forfeited.

You are in control of the counseling relationship and may choose at any time to end the therapeutic relationship. If at any time you are dissatisfied with my services as a therapist, you have a right to let me know. If you do not feel that I will resolve your complaint, you may file a formal complaint through contact with the Texas Board of Examiners of Licensed Professional Counselors at 1-800-942-5540. You are responsible for any appointments that are not canceled at least 24 hours prior to the appointment time with the EXCEPTION OF AN EMERGENCY. **If you need to cancel an appointment a 24 hours' notice must be given otherwise a fee will be charged of $150 for the missed appointment.**

_____ Initials

CONTACT INFORMATION

- Counseling by Penny staff may leave appointment reminders or contact me via texting/calling this phone number _____
- Counseling by Penny staff may leave appointment reminders via email _____
- Counseling by Penny staff can call this emergency contact in the event I cannot be reached _____

I have read the information contained in this Informed Consent. I consent to treatment as described in this form. I have read a copy of the Confidentiality/HIPAA Practices. I understand this agreement.

Signature _____ Date _____

INSURANCE

Insurance card with this form to be photocopied

Name of Insured: _____ SSN: _____
Insured's DOB: _____ Insurance Carrier: _____
Benefit/Eligibility Phone Number: (_____) _____ - _____
ID#: _____ Group#: _____
Deductible: _____

Person responsible for bill: _____
Address: _____ CITY: _____ ST: _____
ZIP: _____

Insured's Employer: _____
Address: _____ CITY: _____ ST: _____
ZIP: _____

I authorize the release of any medical or other information necessary to process this claim.
_____ Parent Initials

I authorize payment of medical benefits to the provider of services. I understand that I am responsible for my bill, not my insurance company. I am aware that if my insurance company declines payment, I am responsible for my bill.
Signature _____ Date_____

Please describe your reason(s) for seeking treatment at this time (Include when the problem started):
_____
_____
How would you know you are doing better than before you started counseling?
_____
_____
_____
Please list other health care professionals you currently see:
_____
_____
Please list any other health problems:
_____
_____
Please list any current medications and dosage:
_____
_____
Have you ever received counseling before? If yes, please indicate when, for how long, with whom, and
reason(s) for treatment
_____
_____
Please list any relevant family history (family members, mental health diagnosis, abuse, divorce, etc.) or
additional information related to your mental health:
_____
_____
_____

Please indicate past or current struggles:

___Depression ___Family Conflict ___Anger
___Chronic Illness ___Grief/Loss ___Domestic Violence
___Relationship Issues ___Eating or Weight Problem ___Phobias/Fears
___Anxiety ___Behavioral Problems
___Obsessions/Compulsions
___Chronic Pain ___ADHD ___Manic Episodes
___Sexuality/Sexual Issues ___Abuse/Victimization ___Trauma
___Stress ___Schizophrenia/Psychosis ___Legal Matters
___Loneliness/Isolation ___Drug/Alcohol ___Suicidal Thoughts

Other: _____ (Please explain)

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past **TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score