Donnie Van Curen, LMFT

3917 East Memorial Road, Edmond, OK 73013
(405)823-4302
COUNSELING1820.COM

FIRST SESSION INSTRUCTIONS

Please fill out and bring these forms to your first session. When you arrive, enter the front double glass doors of the building. I will meet you in the lobby at the time of your appointment.

I encourage you to reflect on your goals for counseling. You may want to write a list of the reasons you've decided to begin counseling and what you hope to accomplish. We will talk about your hopes and goals for our time together in the first session.

<u>Forms to fill out, sign & bring to your first session</u>:

- *Client Information (2 pages)-one for each person*
- *Professional Disclosure Statement (3 pages)*
- *Payment Card Authorization (1 page)-or a check or cash*

- *"No Secrets" Policy with Couples or Families (1 page)-for couples and families*

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Client Information (Children)

(A separate form is needed for each person coming to counseling)

Messages Ok?

Yes No

Full Name:_____ Home Phone:_____ ☐ ☐

Date of Birth (DOB):_____ Work Phone:_____ ☐ ☐

Sex:_____ Cell Phone:_____ ☐ ☐

Email Address: _____ ☐ ☐

Street Address: _____

City: _____ State: _____ Zip: _____

Birth Father's Name: _____ Birth Mother's Name: _____

Occupation: _____ Occupation: _____

List all siblings (*living with client or not*) **AND** any other people living with client:

Yes or No

Name:_____ DOB: _____Living with You: ☐ ☐ Parents: _____

Name:_____ DOB: _____Living with You: ☐ ☐ Parents: _____

Name:_____ DOB: _____Living with You: ☐ ☐ Parents: _____

Name:_____ DOB: _____Living with You: ☐ ☐ Parents: _____

Name:_____ DOB: _____Living with You: ☐ ☐ Parents: _____

Name:_____ DOB: _____Living with You: ☐ ☐ Parents: _____

Client attends: (circle one): Church / Synagogue / Temple / Others_____ / Not Applicable

Where (Name): _____ City: _____

In what year was clients last physical and/or blood test? _____

List major medical problems, surgeries, recent hospitalizations, and/or health conditions:

_____

_____

List medications or recreational drugs you are currently taking:

	Name of Medication	Dosage	To Treat
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Please list any addictions or *possible* addictions: _____

_____

Person to contact in case of an emergency: _____

Phone number: _____ Relationship: _____

Please take a moment to describe the clients presenting problem(s); _____

_____

_____

_____

Has the client ever been involved in any type of counseling? Yes No (circle one)

If yes, list diagnosis: _____

Date of diagnosis: _____ Hospitalized because of it? _____

Is client currently having thoughts of killing or seriously injuring yourself? Yes No (circle one)

How did you hear about me? _____

May I thank them for referral? Yes No (circle one)

_____ _____

Signature *Date*

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Professional Disclosure Statement

Counseling with families, couples and individuals

Welcome! This paperwork has been prepared for you to inform you of my qualifications and what you can expect from me as a therapist. Please read this form carefully and sign/initial in the appropriate places. Feel free to ask questions or discuss this information with me at any time.

A. Philosophy and Approach to Therapy:

My philosophy of therapy is holistic, meaning that I believe that people are made up of many parts – body, soul (mind, emotions, will) and spirit. I am a Christian. I believe we are created for relationship. We know ourselves in the context of our relationships. Healing occurs through repairing relationships and altering our interactions within those relationships.

My approach to therapy is from a systemic perspective. I believe that people work in relationship systems and each person in the relationship is important to the health of the whole. When relationships become out of balance, it is a result of many different factors or patterns, which can be examined in the therapy sessions. I place a strong emphasis on healthy communication, problem solving and emotional connections.

B. Code of Ethics:

As a marriage and family therapist, I endeavor to adhere to the American Association for Marriage and Family Therapy ("AAMFT") Code of Ethics and the laws of the state of Oklahoma.

C. Formal Education and Training:

☐ Licensed Marital & Family Therapist (#1012)
☐ Master of Arts in Marriage and Family Therapy from Southern Nazarene University

D. Professional Boundaries:

I will not acknowledge the existence of our relationship outside of the therapy session unless initiated by you. The therapeutic relationship is a professional relationship and therefore will not be a social or business relationship at anytime. Such a relationship, in my view, would undermine our purposes of therapy and limit the process. Given this, I don't participate with clients in social networking sites or as an employment reference.

E. Risks in Counseling:

Counseling may be tremendously beneficial, while at the same time there are some risks. The risks may include the experience of intense and unwanted feelings, including sadness, fear, anger, guilt, or anxiety. It is

important to remember that these feelings may be natural and normal and are an important part of the counseling process. Other risks of counseling may include: recalling unpleasant life events, facing unpleasant thoughts and beliefs, increased awareness of feelings, values and experiences, alteration of an individual's thinking, and calling into question some or many of your beliefs and values. For couples counseling, although the goal is to improve communication and increase closeness, there is no guarantee of those results. I am available to discuss any of your assumptions, concerns, fears, issues, problems, or possible side effects of our work together.

Initials:_____

F. <u>Your rights as a client</u>:

1. You are entitled to information about any procedure, method of therapy, techniques, and possible duration of therapy upon your request. If you desire, I will explain my usual approach as well as qualifications.

2. You have the right to decide not to receive therapeutic assistance from me or to get a second opinion from another therapist. I will provide you with the names of other qualified professionals whose services you might prefer.

3. You have the right to expect confidentiality within the limits described as follows. There are certain situations in which I am required by law without your permission to reveal information obtained during therapy. These situations are: (a) if you threaten bodily harm or death to yourself or another person; (b) if I am compelled by a court of law; (c) if you reveal information relating to physical abuse, sexual abuse, or neglect of a child or elderly person. With respect to child abuse, I am not permitted to investigate if the information is true or not. I am considered a "mandatory reporter" and must report any information of the abuse of a child.

Also, I may discuss certain aspects of our sessions in consultation or case presentations with other therapists and helping professionals. Your surnames and other identifying information are not disclosed. Everything discussed in consultation is confidential. The purpose is to aid and enhance our counseling sessions.

In addition, for couple's counseling and family counseling, I maintain a "no secrets policy." I believe that secrets hinder the intimacy building process. Therefore, anything one partner tells me outside the presence of the other partner may be discussed with either partner based on my professional judgment. I explain this in more detail in the "No Secrets Policy" page.

See the "Notice of Privacy Practices" for further explanation of how the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule applies to counseling.

Initials:_____

4. Email/text communication: Your confidentiality rights described in #3 above apply to email and text communication. However, email and text have certain risks that are not present with speaking in person or phone calls. The risks of email and texts are that they could fail to be received if sent to the wrong email address or phone number or if the recipient just does not notice them. Others who have access to the email account, computer or phone as well as hackers or Internet service providers could breach confidentiality in transit or at either end. To mitigate the risks with email I use passwords to protect confidentiality on my end. Nevertheless, if you wish to avoid these risks, please let me know by selecting "No" under the "Messages OK" box on the "Client Information" sheet next to your email address. If you've checked "yes" in the "Messages OK?" box, I may use your email address provided as well as any other email address you may later provide to me for direct communication with you. If you initiate a text to me, I assume it is OK for me to reply via text unless you state otherwise. I suggest email and text are only used to schedule appointments.

5. You have the right to end therapy at any time without any moral, legal, or financial obligation other than those obligations already accrued including, but not limited to, the right to pay for services already rendered and cancelation fees.

6. If you request in writing, your records can be released to any person or agency you designate (note that consent from all clients in the treatment group is needed for a release of records). Also, you may authorize me, in writing, to consult with another professional about your therapy.

7. I may not always be immediately available to you. If you are having thoughts of suicide and are unable to speak with me, please contact the National Suicide Prevention hotline at 800-273-TALK (8255), or 911 or go to the nearest emergency room.

G. Appointment Issues:

In order to serve you in the best way possible and meet your needs for therapy services, the following are my appointment policies.

1. I expect 24-hour notice from you if you need to change your appointment time. If I am not given this notice, I will expect payment for the scheduled time at our agreed upon rate. For clients in couple's counseling, unless we have planned otherwise, both partners must be present at the appointment time for the session to begin and continue. Children are not permitted in the counseling room except when part of a scheduled family session.

2. If you are late for a session, the time of your session may be shortened as we will have to end at the scheduled time, but you will be required to pay for a full session.

3. If you haven't called me and are late for an appointment, I will wait for up to 15 minutes, and then assume you are not coming. The regular fee will still be expected for the time I reserved for you.

H. Financial Consideration

1. ***In Office*:** My standard fee for therapy in my office is **$130** per **45-50-minute session** ("Agreed Upon Rate"). If we agree to longer or shorter sessions, you will be charged accordingly. **Via phone:** My standard fee for therapy via the phone is $150 per 50-minute session ("Phone Agreed Upon Rate"). A "*Yearly Contract*" program has been establish for families and can be discussed in more detail at your first session if you have interest and qualify.

2. Payment in full is expected for each session and is made with the debit or credit card (Visa, MasterCard or Discover) I have on record. Cards linked to Health Savings Accounts or a Flexible Spending accounts are acceptable. Please fill out the attached Payment Card Authorization form for the card you would like to keep on record. If you would like to use an alternate method for payment, we can discuss it in our first session.

3. There may be a charge for other services, including consultation with other professionals, preparation of reports or correspondence, any necessary court appearances, and occasional phone calls lasting over 10 minutes or frequent conversations of any duration. The fee will be agreed on by both of us before the performance of these services. If the services require me to be out of the office, a minimum 8-hour day, including travel time, is due at the time of scheduling the services. Additionally, there is a $15 fee for returned checks.

4. A receipt with all essential information required for insurance reimbursement is provided per request. Depending on your policy, you may or may not be entitled to partial or full reimbursement. I assume no responsibility for assuring that you qualify for insurance or other reimbursement for my services.

5. Therapists have a right to seek legal recourse to recoup unpaid balances. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality. In the event that it becomes appropriate for me to resort to legal remedies to collect any amount you owe, then in addition to the balance due you will also be responsible for all costs of collections, attorney's fees, court costs, and all other related expenses including interest thereon at the highest lawful rate.

6. When diagnostic testing is appropriate and recommended, some psychological assessment needs may be referred to another mental health professional who will determine his or her own fee.

Consent to Treatment:

I affirm that prior to becoming a client of Donnie Van Curen, he gave me sufficient information to understand the nature and the nature of confidentiality. In accordance with HIPPA regulations, a copy of the "Notice of PrivacyPractices" has been made available to me. I consent to participate in evaluation and treatment and I understand that I may refuse services at any time. I am also aware that the therapist will periodically consult with clinical supervisors, as required, on client issues. I have read the above and both understand and agree to the financial consideration and the appointment policy. My signature below affirms my informed and voluntary consent to receive therapy in full accordance with the terms set forth herein. With the understanding of the above information and conditions, I agree to participate in therapy.

Signature _____ Date _____

Signature _____ Date _____

Therapist's Signature _____ Date _____

Payment Card Authorization

I authorize Donnie Van Curen to charge the card below for $130 including phone session (including violations of the policy on 24-hour notice for cancellations) as well as other charges (books, classes, etc.) we both agree upon as stated in the *Professional Disclosure Statement.*

Card (check) ☐  ☐  ☐  ☐ 

Type (check) Card ☐ *Credit Card* ☐ *Debit Card** ☐ *HSA or Flex*

Name on Card:

Card Number:

Expiration: /

*CVV2/CID**:*

Billing Address *Street:*

City: *State:* *Zip:*

Signature: _____

Date: _____

**Will be charged as a credit card through the Visa/MC/Discover/AMEX network.*
***This code is on the back of the card in the signature block and consists of 3 digits (or on the front of the AMEX with 4 digits)*

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"No Secrets" Policy with Couples or Families

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During the course of my work with a couple or a family, I may see or speak separately with a smaller part of the treatment unit (e.g., an individual or two siblings). These discussions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such discussions with me, please understand that generally these discussions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those discussions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual discussion (or a discussion with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure**.** Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you may want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the couple or family by

preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual discussion may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to protect the privacy of client information, provide for the electronic and physical security of health and client medical information, and simplify billing and other electronic transactions by standardizing codes and procedures. A piece of this law is known as the HIPAA Privacy Rule. The HIPAA Privacy Rule creates a minimum federal standard for the use and disclosure of Protected Health Information (PHI) by health care organizations. One of the requirements of the Privacy Rule is that I give to you a Notice of Privacy Practices (NPP) that describes your rights and protections regarding your health care records (PHI). You may request a copy (paper or electronic) of this notice at any time. This document describes how your PHI, as a client of DonnieVan Curen, may be used and disclosed.

Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material known as "Psychotherapy Notes" which are not available to outside sources and in some cases, not to the client. HIPAA provides privacy protections about your personal health information (PHI) which could personally identify you. PHI consists of three components: treatment, payment, and health care operations.

A: Commitment to Privacy

I know how important your PHI is and I am committed to respecting and protecting it. In conducting sessions, I will create notes regarding you and your treatment. I am required by law to maintain the confidentiality of all PHI that identifies you.

The terms of this notice apply to all records containing your PHI that are created or retained by me. I reserve the right to revise or amend this notice at any time. Any revision or amendment to this notice will be effective for all your past records that I have created or maintained as well as any records that may be created or maintained in the future.

B. Uses and Disclosures of Mental Health Information (PHI)

Treatment: I may discuss certain aspects of our sessions in consultation. I may use or disclose your PHI to a physician or other healthcare provider where you are also going for treatment in order to coordinate care.

Payment: I may use and disclose your PHI in the billing process to obtain payment for the services provided to you.

Mental Health Care Operations: I may use and disclose your protected PHI for mental health care operations, which will include internal administration such as record keeping, billing, appointment setting and reminders, voicemail messages to you and mailings to your home address.

Your Authorization: In addition to my use of your PHI for treatment, payment or operations, you may also give me written authorization to use your PHI or to disclose it to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your PHI for any reason except those defined in this notice.

Required by Law: I may use or disclose your PHI when I am required to do so by law. This would include responding if a court of law issues a legitimate court order, reporting child or elder abuse and/or neglect to the authorities authorized by law to receive such reports, and disclosure of your PHI to the extent necessary to avert a serious threat to your own safety and health and/or the safety and health of others.

C. Use and Disclosure Requiring Your Written Authorization

I will not use or disclose your confidential information for any purpose other than the purposes described in the notice, without your written permission. For example, I would not supply confidential information to a family member, a research organization or to a prospective employer without your signed consent / request.

D. Individual Rights

1. Access

You have the right to look at or get copies of your PHI in the designated medical record, with limited exceptions (i.e., where assessments designate the use by clinicians only, psychotherapy notes and information compiled in anticipation of litigation, etc.) as long as the PHI is maintained in the record. The charge for requested copies is 50 cents per page, our agreed upon rate per hour for time to locate/copy the PHI and the required postage should you want the copies mailed to you.

In recognition of the importance of the confidentiality of conversations between the counselor and the client in treatment settings, HIPAA permits keeping “psychotherapy notes” separate from the overall “designated medical record.” “Psychotherapy notes” are not the same as your “progress notes” which provide general information about your care and progress each time you have an appointment.

2. Right to Request Additional Restrictions

You may request restrictions on my use and disclosure of protected PHI for treatment, payment, or mental health care operations in addition to those explained in the notice. All requests for such restrictions must be made to me in writing. While I will consider all requests for additional restrictions carefully, I am not required to always agree with the additional requested restriction.

3. Right to Receive Confidential Communications

You may request and I will accommodate any reasonable request that you receive protected PHI by an alternative means of communication.

4. Disclosure Accounting

I will inform you if I disclose your PHI. You have the right to receive a list of instances in which I have disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities.