

# Whitney K. Windham, MA, PsyD, LPC

Mr.  Mrs.  Miss  other: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Referred by: \_\_\_\_\_

Education Level: \_\_\_\_\_

## What is your current gender identity? (Check all that apply)

Sex: Male \_\_\_\_ Female \_\_\_\_ Transgender Male/Transman/FTM \_\_\_\_ Transgender Female/Transwoman/MTF \_\_\_\_

Genderqueer \_\_\_\_ Additional category (please specify): \_\_\_\_\_

May we send a message to you via email?  Yes  No

Email address: \_\_\_\_\_

**(Please note that most standard email does not provide a secure means of communication. There is some risk that protected health information (PHI) contained in an email may be disclosed to, or intercepted by, unauthorized third parties).**

Home Phone: ( ) \_\_\_\_\_  Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

**Please check the box where we may leave you a message about appointments.**

If applicable may we communicate with you via text message? Yes \_\_\_\_ No \_\_\_\_ (If yes, we will use the cell phone number listed above unless you want us to use another number) Cell Phone: ( ) \_\_\_\_\_

**(Please note that "Text messages are generally not secure because they lack encryption, and the sender does not know with certainty the message is received by the intended recipient. Also, the telecommunication vendor/wireless carrier may store the text messages.")**

Marital Status:  Married  Single  Separated  Divorced  Widowed  Partner  Unknown

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  other: \_\_\_\_\_

Race:  Caucasian  African American  Asian  Other: \_\_\_\_\_

Student Status:  Not a Student  Full  Part-time

Employment Status:  Full  Part  N/A Employer: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Previous counseling: Yes  No  Name of counselor \_\_\_\_\_

What brings you to counseling at this time? \_\_\_\_\_

Primary Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

Current medical conditions \_\_\_\_\_

Current medications \_\_\_\_\_

If on psychotropic medications, who prescribes? Name: \_\_\_\_\_

Contact Information of prescriber of psychotropic medications: \_\_\_\_\_

## Consent for Treatment, Authorization, and Release

**CONSENT FOR TREATMENT:** I consent and authorize Turning Point Counseling and Assessment to provide me therapy and to use and release my protected health information (PHI) for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the South Carolina Privacy Notice Form, a copy of which has been made available to me.

**AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION:** I understand that my mental health information, including complete records and billing information, may be released to my insurance company and to other mental health professional and/or mental health institutions for treatment and payment purposes.

**PAYMENT GUARANTEE:** I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles, and non-covered services rendered by Turning Point Counseling and Assessment, including charges for services not covered by my insurance. I consent and authorize Turning Point Counseling and Assessment to contact me by telephone at any number associated with me, including a wireless number and to use a pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account if applicable.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep Turning Point Counseling and Assessment and its independent informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my mental health.

Print Patient's Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Print Legal Guardian's Name: \_\_\_\_\_

Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Whitney K. Windham, PsyD, LPC

451 Folly Road, Suite 104

Charleston, SC 29412

## PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

Welcome to my practice. I hope your visit today will be both pleasant and meaningful. The information in this document will familiarize you with the policies and procedures of my practice. It will also serve as your treatment contract and constitutes a binding agreement between us. Please read it carefully and let me know if you have questions, concerns, or need further clarification.

### **Clinical Services**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and the client and depending on the particular problems the client brings. There are a number of different approaches that can be utilized to treat the problems you hope to address. Psychotherapy is not like visiting a medical doctor, in that it requires a very active effort on your part. In order to be most successful, you will have to work both during our sessions and at home.

Psychotherapy, like everything in life, has both benefits and risks. Sometimes psychotherapy involves recalling and talking about unpleasant events in your life. Because of this, the risks of psychotherapy sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, disappointment, loneliness, and helplessness. Psychotherapy also has been shown to have benefits for people who undertake it, often leading to a significant reduction in of feelings of distress, better relationships, and/or the resolution of specific problems. But, as with most things in life, there are no guarantees about what will happen.

During the first few sessions, I will gather information in order to evaluate your therapeutic needs. I will also offer you my initial impressions and discuss an initial treatment plan. You should evaluate this information along with your own sense of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to refer you to another mental health professional.

### **Meetings**

My normal practice is to begin with a period of evaluation that will last from 2-4 sessions. During this time, we can both decide whether I am the best person to provide the services that you need in order to meet your treatment goals. If we continue, I will usually schedule one 50-minute session per week, at a mutually agreed time, although some sessions may be longer or more frequent.

### **Professional Fees**

An initial evaluation is \$165 and lasts for 60 minutes. Each session following the initial session is 50 minutes and \$150. I accept cash, Venmo, and all major credit cards. In addition to weekly appointments, it is my practice to charge for other professional services you may require such as: report writing, telephone conversations which last

more than 30 minutes, attending meetings or consultations with other professionals which you have authorized, preparing records or treatment summaries, or the time required to perform other services which you may request of me. In unusual circumstances, you may become involved in a litigation, which may require my participation. If that were to happen, you would be expected to pay for the professional time required even if I am compelled to testify by another party. Because of the complexity and difficulty of legal involvement, I charge \$175 per hour to prepare for, travel to, and attend any legal proceeding.

### **Contacting Me**

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 a.m. and 5 p.m., I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by my voicemail that I monitor frequently. I will make every effort to return your call within 24 hours, except on weekends and holidays. If you are difficult to reach, please inform me of some times you will be available. If you cannot reach me, and you feel you cannot wait for me to return your call, you will need to call your family physician, or nearest emergency room and ask for the psychologist or psychiatrist on call. If I am unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

### **Limits on Confidentiality**

The law protects the privacy of all communications between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about your care. During consultation, I make every effort to avoid revealing the identity of my clients. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to work together. I will note all consultation in your Clinical Record.
- I am an independent practitioner. There are other mental health professionals that work in this same building. Protected Health Information is not shared with those mental health professionals, and records are separately stored.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by therapist-client privilege. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information
- If a government agency is requesting the information for health oversight activities, I am required to provide it to them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding the client in order to defend myself.

- If I am treating a client who files a worker's compensation claim, I may, upon appropriate request, be required to provide otherwise confidential information to the patient's employer, the insurer, or the Worker's Compensation Commission.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I receive information that gives me reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect, or by acts or omissions that would be abuse or neglect if committed by a parent or caretaker, the law requires that I file a report with the county Department of Social Services. If I believe that a child has been or may be abused or neglected by another person, I must report that to the appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that a vulnerable adult has been or is likely to be abused, neglected, or exploited, the law requires that I file a report to the Adult Protective Services Program. Once such a report is filed, I may be required to provide additional information.
- If I believe that a client presents a clear and substantial risk of imminent, serious harm to another, I may be required to take protective action, including notifying the potential victim, contacting the police, and/or seeking hospitalization for the client.
- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection
- If a client reveals his or her intent to commit a crime, I may be required to take preventative action, such as calling the police.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

### **Professional Records**

I am required to keep treatment records. All records are locked and kept confidential. If you wish to see your records, I prefer you review them in my presence so that we may discuss the contents.

### **Client Rights**

HIPAA provides you with several new or expanded rights with regards to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restriction on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper of this Agreement, the Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

**Minor and Parents**

Clients under 18 years of age who are not emancipated from their parents should be aware that the law allows parents to examine their child's Clinical Records, unless I decide that such access is likely to injure the child, or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly, with teenagers, it is sometimes my policy to request an agreement form parents that they consent to give up their access to their child's records, if they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle to handle any objections he/she may have.

**Billings and Payments**

You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. I do not accept insurance, but I can provide you with a Superbill to submit to your insurance agency to see if they will reimburse you.

**YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.**

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**Print Name****Date:** \_\_\_\_\_

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**Client's Signature**