



• KEMPER ORTON, M.ED., LMHC, NCC •

CLIENT INFORMATION & INFORMED CONSENT

NEW CLIENT: WELCOME!

THANK YOU FOR CHOOSING KEMPER ORTON, M.ED., LMHC, NCC. I REALIZE THAT STARTING COUNSELING IS A MAJOR DECISION AND YOU MAY HAVE MANY QUESTIONS. THIS DOCUMENT IS INTENDED TO INFORM YOU OF POLICIES, STATE AND FEDERAL LAWS, AND YOUR RIGHTS.

CREDENTIALS

PLEASE ALLOW ME TO SHARE SOME INFORMATION ABOUT MY CREDENTIALS. I EARNED A BACHELOR OF SCIENCE DEGREE FROM PENNSYLVANIA STATE UNIVERSITY AND A MASTER'S DEGREE IN COUNSELING AND GUIDANCE FROM CLEMSON UNIVERSITY. I AM A LICENSED MENTAL HEALTH COUNSELOR IN THE STATE OF FLORIDA AND ALSO A NATIONAL CERTIFIED COUNSELOR. I HAVE WORKED FOR SEVERAL AGENCIES IN SOUTH FLORIDA PRIOR TO OPENING A PRIVATE PRACTICE. I PRACTICE SOLUTION-FOCUSED, COGNITIVE-BEHAVIORAL THERAPY, AND LIFE COACHING FOR MOST CONDITIONS, HOWEVER, OTHER TREATMENT APPROACHES ARE USED DEPENDING ON THE PERSON OR CONDITION.

GOALS

THE MAJOR GOAL OF COUNSELING IS TO HELP YOU IDENTIFY AND COPE MORE EFFECTIVELY WITH PROBLEMS IN DAILY LIVING AND TO DEAL WITH INNER CONFLICTS WHICH MAY DISRUPT YOUR ABILITY TO FUNCTION EFFECTIVELY. THIS PURPOSE IS ACCOMPLISHED BY:

1. INCREASING PERSONAL AWARENESS.
2. INCREASING PERSONAL RESPONSIBILITY AND ACCEPTANCE TO MAKE CHANGES NECESSARY TO ATTAIN YOUR GOALS.
3. IDENTIFYING PERSONAL TREATMENT GOALS.
4. PROMOTING WHOLENESS THROUGH PSYCHIATRIC TREATMENT AND/OR PSYCHOLOGICAL HEALING AND GROWTH.

YOU ARE RESPONSIBLE FOR PROVIDING NECESSARY INFORMATION TO FACILITATE EFFECTIVE TREATMENT. YOU ARE EXPECTED TO PLAY AN ACTIVE ROLE IN YOUR TREATMENT, INCLUDING WORKING WITH ME TO OUTLINE YOUR TREATMENT GOALS AND ASSESS YOUR PROGRESS. THERE MAY ALSO BE NEGATIVE CONSEQUENCES IF YOU DO NOT FOLLOW THROUGH WITH RECOMMENDED TREATMENT. YOU MAY BE ASKED TO COMPLETE QUESTIONNAIRES OR TO DO HOMEWORK ASSIGNMENTS. YOUR PROGRESS IN THERAPY OFTEN DEPENDS MUCH MORE ON WHAT YOU DO BETWEEN SESSIONS THAN ON WHAT HAPPENS IN SESSION. **INITIAL HERE:** _____

APPOINTMENTS

APPOINTMENTS ARE USUALLY SCHEDULED FOR 50 MINUTES. CLIENTS ARE USUALLY SEEN WEEKLY OR MORE/LESS FREQUENTLY AS APPROPRIATE. IDEALLY, I WILL SEE YOU AT THE SAME DAY AND TIME EACH WEEK. YOU MAY DISCONTINUE TREATMENT AT ANY TIME, BUT PLEASE DISCUSS THIS IMPORTANT DECISION WITH ME. **INITIAL HERE:** _____

CANCELLATIONS AND MISSED APPOINTMENTS

YOU WILL BE BILLED THE HOURLY RATE (\$100) FOR A SESSION THAT YOU CANCEL (OR DO NOT SHOW FOR) WITH LESS THAN 24 HOURS NOTICE. YOU MAY LEAVE MESSAGES 24 HOURS PER DAY. PLEASE NOTE THAT INSURANCE COMPANIES GENERALLY DO NOT REIMBURSE FOR FAILED APPOINTMENTS SO YOU WILL BE RESPONSIBLE FOR THIS EXPENSE PERSONALLY. INITIAL HERE: _____

EMERGENCIES

IN BETWEEN SESSIONS, IN THE EVENT OF AN EMERGENCY PLEASE CHOOSE ONE OF THE FOLLOWING:

1. CALL 911, 211, OR VISIT YOUR LOCAL EMERGENCY ROOM.
2. CONTACT THE MOBILE CRISIS UNIT AT 383-5777 (NORTH OF SOUTHERN BLVD.) OR 637-2102 (SOUTH OF SOUTHERN BLVD.).
3. CONTACT YOUR PSYCHIATRIST OR GENERAL PRACTITIONER.

INITIAL HERE: _____

CONFIDENTIALITY

ISSUES DISCUSSED IN THERAPY ARE IMPORTANT AND ARE GENERALLY LEGALLY PROTECTED AS BOTH CONFIDENTIAL AND "PRIVILEGED." HOWEVER, THERE ARE LIMITS TO THE PRIVILEGE OF CONFIDENTIALITY. THESE SITUATIONS INCLUDE BUT ARE NOT LIMITED TO: 1) SUSPECTED ABUSE OR NEGLECT OF A CHILD, ELDERLY PERSON, OR A DISABLED PERSON, 2) WHEN IT IS ASSESSED THAT YOU ARE IN DANGER OF HARMING YOURSELF OR ANOTHER PERSON OR YOU ARE UNABLE TO CARE FOR YOURSELF, 3) IF YOU REPORT THAT YOU INTEND TO PHYSICALLY INJURE SOMEONE THE LAW REQUIRES ME TO INFORM THAT PERSON AS WELL AS LEGAL AUTHORITIES, 4) IF I AM ORDERED BY A COURT TO RELEASE INFORMATION AS PART OF A LEGAL INVOLVEMENT IN COMPANY LITIGATION, ETC., 5) WHEN YOUR INSURANCE COMPANY IS INVOLVED, E.G. IN FILING A CLAIM, INSURANCE AUDITS, CASE REVIEW OR APPEALS, ETC., 6) IN NATURAL DISASTERS WHEREBY PROTECTED RECORDS MAY BECOME EXPOSED OR 7) WHEN OTHERWISE REQUIRED BY LAW. YOU MAY BE ASKED TO SIGN A RELEASE OF INFORMATION SO THAT I MAY SPEAK WITH OTHER MENTAL HEALTH PROFESSIONALS OR TO FAMILY MEMBERS.

INITIAL HERE: _____

RECORD KEEPING

A CLINICAL CHART IS MAINTAINED DESCRIBING YOUR CONDITION, TREATMENT, PROGRESS, DATES AND FEES FOR SESSIONS, AND NOTES ABOUT EACH THERAPY SESSION. YOUR RECORDS WILL NOT BE RELEASED WITHOUT YOUR WRITTEN CONSENT, EXCEPT AS OUTLINED IN THE CONFIDENTIALITY SECTION ABOVE. MEDICAL RECORDS ARE LOCKED AND KEPT ON SITE. INITIAL HERE: _____

FEES (SUBJECT TO CHANGE ANNUALLY)

THE FEE FOR THE INITIAL VISIT (90 MINUTES) IS \$125.

EACH 30- MINUTE SESSION THEREAFTER IS \$60.

EACH 50- MINUTE SESSION THEREAFTER IS \$100.

EACH 75- MINUTE SESSION THEREAFTER IS \$125.

PHONE CONSULTATIONS OVER 5 MINUTES: \$2/MINUTE INITIAL HERE: _____

LEGAL MATTERS

IN THE EVENT YOU ARE INVOLVED IN DIVORCE, CHILD CUSTODY, OR OTHER LEGAL MATTERS YOU AGREE THAT YOU WILL NOT SUBPOENA ME TO PROVIDE TESTIMONY OR TO PROVIDE ANY WRITTEN DOCUMENTATION. INITIAL HERE: _____

SOCIAL NETWORKING WEBSITES

IT IS MY POLICY NOT TO SOCIALIZE OR COMMUNICATE WITH CLIENTS VIA SOCIAL NETWORKING WEBSITES (I.E. FACEBOOK, ETC.). ANY ATTEMPTS BY CLIENTS TO MAKE CONTACT WITH ME IN THIS MANNER WILL KINDLY NOT BE RESPONDED TO. INITIAL HERE: _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I HAVE READ AND RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS DOCUMENT. INITIAL HERE: _____

CONTACT

I AGREE TO BE CONTACTED ON MY HOME PHONE (CIRCLE ONE) **YES NO** I AGREE TO BE CONTACTED AT WORK **YES NO** I AGREE TO BE CONTACTED BY CELL PHONE **YES NO** INCLUDING TEXT MESSAGES **YES NO** I AGREE TO BE CONTACTED AT MY HOME ADDRESS **YES NO** I AGREE TO BE CONTACTED BY EMAIL **YES NO** INITIAL HERE: _____

CONSENT FOR TREATMENT

BY SIGNING BELOW, YOU ARE STATING THAT YOU HAVE READ AND UNDERSTOOD THIS POLICY STATEMENT AND HAVE HAD YOUR QUESTIONS ANSWERED TO YOUR SATISFACTION. I ACCEPT, UNDERSTAND, AND AGREE TO ABIDE BY THE CONTENTS AND TERMS OF THIS AGREEMENT AND FURTHER, CONSENT TO PARTICIPATE IN EVALUATION AND/OR TREATMENT. I UNDERSTAND THAT WHILE THE COURSE OF MY TREATMENT IS DESIGNED TO BE HELPFUL, MY PRACTITIONER CAN MAKE NO GUARANTEES ABOUT THE OUTCOME OF MY TREATMENT. FURTHER, THE PSYCHOTHERAPEUTIC PROCESS CAN BRING UP UNCOMFORTABLE FEELINGS AND REACTIONS SUCH AS ANXIETY, SADNESS, AND ANGER. I UNDERSTAND THAT THIS IS A NORMAL RESPONSE TO WORKING THROUGH UNRESOLVED LIFE EXPERIENCES AND THAT THESE REACTIONS WILL BE WORKED ON BETWEEN MY PRACTITIONER AND ME. I UNDERSTAND THAT I MAY WITHDRAW FROM TREATMENT AT ANY TIME.

CLIENT/LEGAL GUARDIAN SIGNATURE DATE

CLIENT PRINTED NAME

LEGAL GUARDIAN PRINTED NAME RELATIONSHIP TO CLIENT

WITNESS SIGNATURE DATE