Spero Counseling

Brianna Wood, MA, LMHCA
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Welcome to Spero Counseling! Before we begin our therapy sessions together, there is some information that you need to know. There is a lot to read but it's very important information as it is our working agreement. Legally, this form is called an "Informed Consent." This informed consent will help you understand better what you can expect from me, and what I expect from my clients. This document will also explain some limitations to what you and I will be doing. Please complete this paperwork **prior to our initial meeting** so that we can spend our time together focusing on the personal concerns that you wish to consult about. I look forward to meeting with you.

What You Can Expect: I work to provide a safe environment for you to explore and evaluate your inner thoughts, feelings, and attitudes. At the beginning of treatment we will create a treatment plan, which includes what you would like to change, and what you and I will do to change it. This helps us know if what we are doing is working for you. Occasionally, I may need to refer you to another therapist if I believe your concerns require specific knowledge that falls outside my scope of practice. Please understand that our initial session is an assessment for both of us to determine whether we want to work together; it is not an indication that I have accepted you as a client or that you have accepted me as a counselor.

Potential Benefits and Risks of Therapy: Therapy is generally not easy work. It may include discussing deep personal information. This may involve analyzing yourself within the context of relationships in love and work, as well as how you think, feel and organize your internal and external worlds. Therapy consist of helping you identify and transform attachments, unexpressed emotions or emotional triggers, unresolved issues, and self-defeating thought paVerns which are causing you emotional pain. At times this process may be painful. It may take a while for you to begin to feel beVer. I can't offer any promises about the results you will experience. Your outcome will depend upon a variety of factors.

I do come to care deeply about my clients: however, I do not have social relationships with clients, even when we have completed our work together. Standard ethical practice says, "Once a client, always a client." This means that ethically I am required to keep the therapeutic relationship intact so that you have the option of returning to counseling with me at any point in the future. I am, however, under no obligation to reengage in therapy with any of my previous clients.

Confidentiality and Exceptions: Under Washington State law and ethics, I am required to follow the professional code of ethical guidelines regarding confidentiality. Information shared in each session is **confidential** and can only be released with your written consent or as required by law. This confidentiality has the following **exceptions** as provided by law:

- If I believe there is a risk that you might harm yourself or someone else, I may be required to contact the authorities or the other person to give them the opportunity to protect you or the other person.
- If you- or anyone else you tell me about- are abusing or have abused children or vulnerable adults, I am required by law to notify the authorities so they can protect others from harm.
- If you become involved in any lawsuit in which your mental health is an issue-such as a child custody dispute or an injury lawsuit in which you claim compensation for emotional pain and suffering-and/or I receive a properly submitted subpoena or court order, I may have to release your information.
- If you file a complaint against me to the state licensing board, you lose the protection of confidentiality.
- When you sign a Release of Information form, giving me permission to share confidential information, then it is no longer considered "confidential" information between us.
- Insurance companies (when applicable) and other third-party payers are given information they request regarding services to clients.

I will keep clinical records of your sessions with me, as required by state law, for seven years beyond the end of therapy, at which time, it will be destroyed. You may ask to see this record and make requests to have corrections or additions made to that record. You will be charged my usual fee in 15 minute increments for the time involved. If copies of your records are requested, you will be charged 30 cents per page in addition to my time. If you are a minor under the age of 18, I may discuss with your parents or guardians some of the information from counseling. Whenever possible, I will obtain your permission prior to doing so.

Training and Degrees: I received my Master of Arts in Counseling Psychology from Northwest University, College of Social and Behavioral Sciences in 2015. This program is fully accredited by the Northwest Commission on Colleges and Universities to award degrees at the associate, baccalaureate, masters, and doctoral levels. My experience includes working with children, adolescents, and their families in community mental health at Ryther through outpatient therapy. I also have experience working in a residential facility with foster youth with complex medical and behavioral issues. I practice under the title of a Washington State Licensed Mental Health Counselor (MC60637000). I participate in supervision with a licensed supervisor to ensure quality and performance for my clients

Counseling Orientation: My approach to counseling is guided by a desire to provide a nonjudgmental and safe environment for my clients to feel comfortable and make progress. During our counseling relationship, we will work together to identify your concerns and create goals. I incorporate Cognitive Behavioral Therapy, Narrative Therapy, Humanistic Therapy, and Family Systems Therapy into my counseling. I work with a variety of issues including anxiety, depression, anger and aggression, stress, communication issues, peer relationships, low self-esteem, parenting, academic underachievement, and behavioral issues.

Fees: The fee for counseling is $115.00 per individual 50-minute session and $135 per 50-minute family session. Fees are adjusted annually on January 1, and will not increase more than $10 per year. For Telehealth sessions, fees are charged through Square. After the intake session, you will be emailed an invoice; payment information must be saved so there is a card on file for subsequent sessions. If in person, payments (cash, check, or via Square) are to be made at the beginning of each session. A $35 fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency.

Missed Appointments: In the event that you are unable to keep an appointment, please notify me via phone a minimum of three days (72 hours) in advance. E-mail and text messages are not adequate notice. If you miss your appointment for any reason and fail to give me adequate notice, you will be responsible for the full fee for the session. If you are late, I will still stop at our regular ending me in order to keep my schedule, and you will will be required to pay for the entire session. In the event of a missed appointment, the bill will reflect a late cancellation instead of a clinical session. Most insurance companies will not reimburse for missed appointments. If I have an emergency, I will notify you as soon as possible of my need to reschedule our appointment.

Legal Proceedings: If you become involved in legal proceedings that require my participation, even if I am called to testify by another party, you will be expected to pay for all of my related time, including preparations, transportation and time in court (both waiting and testifying). Due to the difficulty of legal involvement and my need to obtain my own legal counsel when involved, I charge $250 per hour for preparation and attendance at any legal proceeding.

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Medical Concerns: I am not a medical doctor and therefore, cannot recognize or diagnose medical conditions. It is essential that you obtain a medical examination to determine if there is any medical origin of your psychological problems (e.g. neurological disorders, diabetes, medication side effects, etc.)

Emergency: If you need to reach me, my business cell number is 425-358-1693. I check my messages regularly throughout the day and will try to return calls within 48 hours. If I do not return your call, please call again as your message may have been lost. I do not routinely check messages in the evenings or weekends. If you cannot reach me, please call the Crisis Line at 425-258-4357 or 911.

Each person entering therapy, the individual, each person in the couple, or each family member needs to sign below. ***Your signature(s) below indicates your understanding of and acceptance of the general conditions described in this document, and that you authorize me, Brianna L. Wood, to render counseling for you. This authorization constitutes informed consent without exception and agreement to pay all applicable fees.*** By signing this document, you are stating that you have also read and understood this agreement and received a copy for yourself. My signature indicates accuracy of the information and my declaration to uphold these conditions.

______________________________ ____________________________________ ______________

Client's Name, printed Client's signature Date

______________________________ ____________________________________ ______________

Client's Name, printed Client's signature Date

____ ______________

Brianna L. Wood, MA, LMHC Date

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CLIENT INFORMATION:

Please provide answers to the following questions that apply to you. Some of the questions may produce some anxiety or cause distressful thoughts. ***If some questions trigger feelings that seem overwhelming to you, please skip those questions until we meet, and we'll discuss it together.*** Please understand that all information requested is for the purpose of helping me to better understand and to assist you in reaching your therapeutic goals.

Name:____ Date: _____________

Address:____

City:____Zip Code:_____________________

Date of Birth:____

Home Phone:____ Message okay? Y N

Work Phone:____ Message okay? Y N

Cell Phone:____ Message okay? Y N

Text okay? Y N

Email:____ Message okay? Y N

Marital Status: Single_____ Cohabitating_____Married_____ Separated_____Divorced_____Widowed_____

Is there anyone you authorize me to communicate with?: ____

Is Spirituality important to you? Yes No Neutral

Please briefly explain why you are seeking therapy. What is the problem? How do you see the situation?

____

____

How does this impact your social, work or academic functioning?

____

____

How long have you experienced this? When did it first begin?

____

____

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What have you already done to try to deal with this problem?

____

____

What are you expecting from our time together?

____

____

____

Please list prior counseling experiences you have received. (Use other side if needed)

Psychotherapy Provider:______________________________ Date began___________ Date ended_____________

Reason for Treatment:____

How was your counseling experience? Positive (helpful)_____Negative (hurtful)_____ Neutral_______

Any previous psychiatric inpatient hospitalizations or drug/alcohol rehab experiences: (Use back page if needed)

Place & Dates:____________________________________Reason:____

____

____

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Who can you count on to be your emotional support? (circle all that apply)

Parent/parents spouse sibling(s) children coworkers church

Extended family close friends self-help group neighbor Other:_____________

When do you actually ask for or seek support? Daily____Weekly____Monthly____Rarely____

Which of the following current stressors have you experienced?

	In Past Month	In Past Year
Problem/change in Couple Relationship	__________	__________
Disruption in other Family Relationships	__________	__________
Death of a loved one	__________	__________
Change in work status	__________	__________
Change in residence	__________	__________
Significant health problems	__________	__________
Financial issues	__________	__________
Legal issues	__________	__________

Other significant changes or stressors?

Explain:____

____

____

____

____

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Current symptoms (please mark ALL that apply):

Affect/Energy
Depressed mood
Diminished energy
Diminished interest
Increased irritability
Feelings of guilt
Feelings of hopelessness
Poor concentration
Poor decision-making ability
Increased energy, feeling "high"
Decreased energy

Anxiety
Generalized fears
Shortness of breath
Feeling disconnected
Chest pains
Feelings of "panic"
Hot/Cold flashes
Fears of dying
Muscle tension
Worrying
Heart Pounding
Stomach upset

Sleep Disturbance
Restlessness
Excessive sleep
Nightmares
Night Terrors
Decreased ability to sleep
Change in sleep pattern
Waking in the middle of night
No need for sleep >6 hrs per night

Eating
Increased appetite
Decreased appetite
Weight gain
Weight loss
Binge/Purge
Compulsive Over Eating
Not eating

Avoidance
Fear of specific places
Fear of social situations
Constriction of life style
Fear of leaving the house
Avoidance of many things especially reminders of painful, scary events

Post Traumatic Stress
Intrusive memories
Hyper-vigilance (over watchful)
Easily startled/High strung
Distressed from triggers
Numb body
Uncomfortable body sensations
Agitated / Irritable

Thinking/Cognitions
Racing thoughts
Recurring Troubling Thoughts
Thought of hurting yourself
Thought about hurting others
Hearing things others do not
Seeing things others do not
Feeling invincible
Grand schemes

Emotions
Crying spells
Mood swings
Angry outbursts
Numb (not feeling)

Other
Intense fear of abandonment
Impulsivity (driving recklessly, drinking too much, overspending..)
Identity confusion
Unstable relationships
Need to be center of attention
Anger control issues
Feeling special/unique
Feeling you deserve better than others
Unable to connect with others' feeling

Are you suicidal? Yes________ No _______ **Are you homicidal?** Yes________ No _______

Have you had any thoughts of suicide or ever attempted suicide? (If yes, please provide dates/details)

____

____

Have you discussed this information with your physician? Yes No

When was your last physical exam?___________________________

Any current medical or health problems you are dealing with? Please explain. (e.g. injuries, illnesses, allergies etc…)

____

____

Please list any medications you have EVER taken and why they were prescribed:

Medication:_________________________________For:________________Amount:_______Date Began:________

Medication:_________________________________For:________________Amount:_______Date Began:________

Medication:_________________________________For:________________Amount:_______Date Began:________

Medication:_________________________________For:________________Amount:_______Date Began:________

History of abuse/trauma (Circle Yes or No):

Yes No Has anyone ever hit, slapped, kicked, punched, or restrained you against your will?
Yes No Has anyone ever touched you in ways you were not comfortable?
Yes No Have you ever been sexually assaulted and/harassed?
Yes No Have your ever been verbally/emotionally abused?
Yes No Have you ever been abused by a church, a pastor, pastoral counselor?
Yes No Have you been mistreated and/or abused by any professional? (e.g. therapist, doctor, instructor)
Yes No Have you ever been threatened with serious physical harm or death?
Yes No Have you been involved in any serious auto accidents, or other accidents?
Yes No Have you experienced or witnessed war combat?
Yes No Have you experienced a serious natural disaster?
Yes No Have you witnessed a loved one experiencing any of the above?
Yes No Have you ever suffered trauma/injury to the head? *If yes, please explain:*

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Behaviors:

How many alcoholic beverages do you drink? ________per day _______per week

What kind of alcohol (beer, wine, vodka, etc…)_________________________________

Do you binge drink? Yes_________No____________How often?__________________

How often do you use recreational drugs? _________per day _________per week

How often do you use pornography? __________per day __________per week

Do you keep this a secret from your spouse/significant other? Yes No

Are you concerned about the effects and/or the amount of time involved? Please describe:____________________

____

Do you feel like you have any addictive behaviors not listed here? Please explain:____________________________

____

What is your present level of commitment to address the issues you are currently aware of as well as any underlying issues which may arise during the process of therapy? (please circle one)

1 2 3 4 5 6 7 8 9 10 (10=100%)

What are three of your major strengths?

1. ____
2. ____
3. ____

I have answered the following questions truthfully to the best of my ability. I am fully aware that based on my diagnosis, I may be referred to another therapist if my diagnosis is out of the scope of her practice.

_______________________________ _______________________________________ ________________

Print Name Signature Date